

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3434

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH: COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Glyndon</b>		LENGTH OF STAY (In this place) <b>83 yrs</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Glyndon</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Butler Road</b>		STREET ADDRESS (If rural, give location) <b>Butler Road</b>			
3. NAME OF DECEASED (Type or Print) <b>Edward</b>		(First) (Middle) (Last) <b>Allender</b>		4. DATE OF DEATH <b>April 29, 1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>March 8, 1868</b>	9. AGE last birthday <b>83</b> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Co.</b>	
13. FATHER'S NAME <b>Thomas L. Allender</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No. <b>None</b>		17. INFORMANT <b>Fletcher Allender, Reisterstown, Md.</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <b>Myocarditis - chronic</b>	<b>10/24/51</b>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <b>virus infection of respiratory tract</b>	<b>2/23/51</b>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **1-1-51** to **35-4-29-51**, that I last saw the deceased  
alive on **4-29-51**, 19**51** and that death occurred at **11:30 a.m.**, from the causes and on the date stated above.

SIGNATURE <b>James L. Saffell</b>	(Degree or title) <b>M.D.</b>	ADDRESS <b>Reisterstown Md</b>	DATE SIGNED <b>5/1/51</b>
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>May 2, 1951</b>	NAME OF CEMETERY OR CREMATORY <b>All-Saints</b>	LOCATION (City, town, or county) <b>Reisterstown, Md.</b>
DATE REC'D BY LOCAL REG. <b>4-30-51</b>	REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>	24. FUNERAL DIRECTOR ADDRESS <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 3 1951  
BUREAU V. S.

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 35-

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - White Hall</u> LENGTH OF STAY (In this place) <u>20 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - White Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bluemount.</u>		STREET ADDRESS (If rural, give location) <u>Bluemount.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John M. Baker</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 9 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 16, 1900</u>
9. AGE last birthday <u>50</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Hoffmanville, Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Operator</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas E. Baker.</u>		14. MOTHER'S MAIDEN NAME <u>Kattie Florstead.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <u>Yes. 1/1/42 to 1/1/43</u>		16. SOCIAL SECURITY NO. <u>214-01-0199</u>	
17. INFORMANT <u>Bessie Baker - White Hall, Md. R.D.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary occlusion</u>		<u>5 1/2 hrs.</u>	
Antecedent cause(s) (b) <u>4/20/1</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>94a</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>A. M. Frances</u>		DATE SIGNED <u>4/9/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>April 13, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Pine Grove E. B. Parkton, Balto. Co., Md.</u>		LOCATION (City, town, or county) (State) <u>Parkton, Balto. Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Jacob Starkenstein, New Freedom, Pa.</u>		ADDRESS <u>290236 Pa.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 17 1951

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3436  
Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Md.</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Woodlawn</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Woodlawn</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>5512 Hutton Ave.,</b>		STREET ADDRESS (If rural, give location) <b>5512 Hutton Ave.,</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>William</b> (Middle) <b>Edward</b> (Last) <b>Ball</b>	4. DATE OF DEATH (Month) <b>Apr.</b> (Day) <b>24,</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 2, 1878</b>
9. AGE last birthday <b>72</b> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Wireman</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Gas. &amp; Elec. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Stephen Ball</b>	
14. MOTHER'S MAIDEN NAME <b>Louise Joiner</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	
16. SOCIAL SECURITY No. <b>212-05-4775A</b>		17. INFORMANT AND ADDRESS <b>Mrs. Rose E. Ball 5512 Hutton Ave.</b>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Metastasis of Cancer</b>		19. a. DATE OF OPERATION <b>1942</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Antecedent cause(s) (b) <b>Carcinoma of Colon</b>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>153X 46e</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Colon</b>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Apr. 15, 1951**, to **Apr. 23, 1951**, that I last saw the deceased alive on **Apr. 23, 1951**, and that death occurred at **3:00** m., from the causes and on the date stated above.

SIGNATURE <b>A. C. Smith</b>		ADDRESS <b>4509 Liberty Highway, Baltimore, Md.</b>	
23. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	DATE <b>4-26-1951</b>	NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>
DATE REC'D BY LOCAL REG. <b>4/25/51</b>	REGISTRAR'S SIGNATURE <b>Dr. H. H. Smith</b>	24. FUNERAL DIRECTOR ADDRESS <b>G. Howard Strong 3207 W. North Ave.,</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

540588

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3438

Reg. Dist. No. 4X

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hosp.		STREET ADDRESS (If rural, give location) 2500 Woodbrook Avenue	
3. NAME OF DECEASED (Type or Print)	(First) EDWARD (Middle) L. (Last) BOOKER	4. DATE OF DEATH (Month) (Day) (Year) April 9 19 51	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9-1-96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevadore		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 54 yrs.
11. BIRTHPLACE (State or foreign country) Charlotte Co., Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Betty Mae Byrd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause 002x 13x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(a) TUBERCULOSIS, CHRONIC, PULMONARY, FAR ADVANCED ACTIVE (b) (c)	UNKNOWN
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ARTERIOSCLEROTIC HEART DISEASE		UNKNOWN
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 8, 19 51, to April 9, 19 51, that I saw the deceased

and that death occurred at 11:30 A.M., from the causes and on the date stated above.  
(Degree or title) ADDRESS DATE SIGNED

IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 4-9-51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 4-13-51	NAME OF CEMETERY OR CREMATORY Baltimore National	LOCATION (City, town, or county) (State) Baltimore, Maryland
DATE REC'D BY LOCAL REG. 4/10/51	REGISTRAR'S SIGNATURE D.W. Redlich	24. FUNERAL DIRECTOR ADDRESS Mrs. Samuel T. Hemsley 578 W. Biddle St., Baltimore, Maryland	

MARGIN RESERVED FOR BINDING

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3437

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH: COUNTY <u>Balto</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Ind.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		LENGTH OF STAY (in this place) <u>11 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sherwood Rd.</u>				STREET ADDRESS (If rural, give location) <u>Sherwood Rd.</u>	
3. NAME OF DECEASED (Type or Print)		(First) <u>Docting</u> (Middle) <u>Ethel</u> (Last) <u>Barlow</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-21-1922</u>	9. AGE last birthday <u>28</u> yrs.	If under 1 year Months   Days   Hours   Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Co. Ind.</u>	
13. FATHER'S NAME <u>Wm. R. McWhorter</u>		14. MOTHER'S MAIDEN NAME <u>Therese Coffell</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT AND ADDRESS <u>Edwood Barlow, Cockeysville Rd.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

593X Immediate cause	(a) <u>Rheumatic Heart Disease</u>	INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
95b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Rheumatic Fever - not active at time of death.</u>	<u>?</u>
	(c) <u>Cardiac Cirrhosis</u>	<u>6 mos.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>acute Nephritis &amp; Uremia (8-28-51)</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb., 1949, to 4-13, 1951, that I last saw the deceased alive on 4-13, 1951, and that death occurred at 8:50 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>4-16-51</u>	NAME OF CEMETERY OR CREMATORY <u>Wm. J. Chikoff</u>	LOCATION (City, town, or county) <u>Wm. J. Chikoff, Balto Co. Ind.</u>	(State) <u>Ind.</u>
DATE REC'D BY LOCAL REG. <u>4-14-51</u>	REGISTRAR'S SIGNATURE <u>Wm. J. Chikoff</u>	24. FUNERAL DIRECTOR <u>Landon M. Brooke, Sparks, Md.</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3439

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>BALTO</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>WOODSTOCK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PURAB-WOODSTOCK MD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WOODSTOCK COLLEGE</u>		STREET ADDRESS (If rural, give location) <u>—</u>	
3. NAME OF DECEASED (Type or Print) <u>REV WILLIAM J. BROSMAN S.J.</u>		4. DATE OF DEATH (Month) <u>APRIL</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>April 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIEST.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE last birthday <u>86</u> yrs. If under 1 year Months Days If under 24 hrs. Mln.
11. BIRTHPLACE (State or foreign country) <u>NEW YORK CITY.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13. FATHER'S NAME <u>NOT KNOWN</u>		14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT <u>WOODSTOCK RECORDS</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Uremia</u>			<u>4 days</u>
450.0 Antecedent cause(s) (b) <u>arteriosclerosis, aneurysm, Fibrillation</u>			
59.1 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Pulmonary edema</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>arthritis.</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1940, 19....., to ap 22, 1951, that I last saw the deceasedalive on ap 21, 1951, and that death occurred at 1 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Harold H Burns MD 118 C. Caper St. Baltimore Md. ap 23, 1951

23. BURIAL, CREMATION	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>APRIL-25-51</u>	<u>WOODSTOCK CEM</u>	<u>WOODSTOCK COLLEGE</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/23/51</u>	<u>B.W. Hedrick</u>	<u>Bernard B Harlan</u>	<u>121 E WEST ST</u>	

MARGIN RESERVED FOR BINDING

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3440

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ellicott City (Grays)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ellicott City (Grays)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>River Road</u>		STREET ADDRESS (If rural, give location) <u>River Road</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>George Bernard Brown, Sr.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4-15-51</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widower</u>	8. DATE OF BIRTH <u>5-22-1875</u>
9. AGE last birthday <u>75</u> yrs.		10. If under 1 year 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>County Roads</u>	
11. BIRTHPLACE (State or foreign country) <u>Ellicott City, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John H. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Alberta Stultz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>William Brown, Catonsville, Md</u>	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cardiac Failure

INTERVAL BETWEEN ONSET AND DEATH

Immediate

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic Cardio-Vascular Disease4 yearsII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 7, 1948, to April 15, 1951, that I last saw the deceased alive on April 15, 1951, and that death occurred at 1 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William F. JassanyM.D.Ellicott City, Md.4/15/51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>4-18-51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	LOCATION (City, town, or county) <u>Ellicott City, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>4/17/51</u>	REGISTRAR'S SIGNATURE <u>V E. Harry</u>	24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u>	ADDRESS <u>Ellicott City, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VVV 936

RECEIVED

APR 19 1951

BUREAU W. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3441

1. PLACE OF DEATH COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Fort Howard</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Baltimore 30</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Vet. Adm. Hosp., Ft. Howard, Md.</b>		STREET ADDRESS (If rural, give location) <b>934 S. Sharp Street</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>JAMES</b>	(Middle) <b>E.</b>	(Last) <b>BROWN</b>
6. SEX <b>Male</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3-5-92</b>	9. AGE last birthday <b>59</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>Auen Brown</b>		14. MOTHER'S MAIDEN NAME <b>Susan Williams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY No. <b>217-03-4695</b>	
17. INFORMANT AND ADDRESS <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>		18. MEDICAL CERTIFICATION	

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **CARCINOMA, RIGHT LUNG**

Antecedent cause(s)

(b) **NONE**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

**NONE**

### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
**INJURY**

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☒ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan. 9, 1951**, to **April 19, 1951**, that I saw the deceased

**and that death occurred at 6:45 A.M., from the causes and on the date stated above.**

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 4-19-51**

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

**Roland A. Brown 123 W. Montgomery Street**

**Baltimore, Maryland**

**Isaiah L. Brown 140546**

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 34424

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>17 S. High St.</u>	
3. NAME OF DECEASED (Type or Print) <u>WILLIAM</u> (First) (Middle) <u>(NMI)</u> (Last) <u>BROWN</u>		4. DATE OF DEATH <u>4-14-51</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>3-25-99</u> Year
9. AGE last birthday <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>beer truck operator</u>	
11. BIRTHPLACE (State or foreign country) <u>Apiary Oreg.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Brown</u>		14. MOTHER'S MAIDEN NAME <u>Trene Loman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-1</u>		16. SOCIAL SECURITY NO. <u>213-07-0237</u>	
17. INFORMANT AND ADDRESS <u>Clinical Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>			

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Pulmonary Tuberculosis Bil. far Advanced</u>	<u>unknown</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) _____	
	(c) _____	

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-27, 1950, to 4-14, 1951. XXXXXX saw the deceased XXXXXX and that death occurred at 2:45 A.M., from the causes and on the date stated above.

SIGNATURE <u>GENE D. TRETTIN, M.D. VAH FT. HOWARD, MD.</u>	(Degree or title)	ADDRESS <u>5501 Frederick Ave. Balto. Md.</u>	DATE SIGNED <u>4-14-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/17/51</u>	NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>	LOCATION (City, town, or county) (State) <u>5501 Frederick Ave. Balto. Md.</u>
DATE REC'D BY LOCAL REG. <u>4/16/51</u>	REGISTRAR'S SIGNATURE <u>A W Hedrick</u>	24. FUNERAL DIRECTOR <u>Mildred J. Blight</u>	ADDRESS <u>6009 Harford Rd. Balto. Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3443 38

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Towson</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Towson</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>520 Park Avenue</b>		STREET ADDRESS (If rural, give location) <b>520 Park Avenue</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>ROLAND</b> (Middle) <b>T</b> (Last) <b>BURKE</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 27, 1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 18, 1880</b>
9. AGE last birthday <b>70</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Commission Merchant</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Produce</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Alonzo J. Burke</b>	
14. MOTHER'S MAIDEN NAME <b>Georgianna Kroh</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT AND ADDRESS <b>Mrs. Roland T. Burke, 520 Park Ave., Towson</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <b>420.0 ACUTE CORONARY OCCLUSION</b>		<b>FEW MINUTES</b>
(b) Antecedent cause(s) <b>93d PREVIOUS CORONARY OCCLUSION; HYPERTENSIVE AND ARTERIOSCLEROTIC HEART DISEASE.</b>		<b>4 MOS.</b>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN)	(COUNTY)
(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **DECEMBER**, 19**50**, to **APRIL**, 19**51**, that I last saw the deceased alive on **APRIL 26**, 19**51**, and that death occurred at **8:20** p.m., from the causes and on the date stated above.

SIGNATURE <b>Donald L. Somerville, M.D.</b>	(Degree or title)	ADDRESS <b>25 W. Penna. Ave. Towson 4, Md.</b>	DATE SIGNED <b>4/27/51</b>
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>May 1, 1951</b>	NAME OF CEMETERY OR CREMATORY <b>Jessup's Methodist Cemetery</b>	LOCATION (City, town, or county) (State) <b>Cockeysville, Balto. Co., Md.</b>
DATE REC'D BY LOCAL REG. <b>4/30/51</b>	REGISTRAR'S SIGNATURE <b>R. W. Hedrick</b>	24. FUNERAL DIRECTOR <b>John Burns' Sons,</b>	ADDRESS <b>Towson, Maryland</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

3444

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>	
TOWN <u>Fullerton</u>		TOWN <u>Fullerton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Oak Summit Ave</u>		STREET ADDRESS (If rural give location) <u>Oak Summit Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Michael (First) Joseph (Middle) Byrne (Last)</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>2-20-1876</u>
9. AGE last birthday <u>75</u> yrs.		10. AGE last birthday If under 1 year: Months <u>8</u> Days <u>8</u> Hours <u>1951</u> Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Freight Handler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRR</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Peter Byrne</u>		14. MOTHER'S MAIDEN NAME <u>Rose Byrne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>716-03-0985</u>	
17. INFORMANT <u>Mrs Kate Byrne - Oak Summit Ave</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Heart disease, myocarditis, chronic, decompensated</u>		<u>1 yr +</u>	
Antecedent cause(s) (b) <u>Hypertension</u>		<u>unknown</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Rollin C. Hudson M.D., D.M.E.</u>		DATE SIGNED <u>4/8/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Funeral</u>		DATE THEREOF <u>4-11-51</u>	
NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		LOCATION (City, town, or county) <u>Balto</u> (State) <u>MD</u>	
DATE RECD BY LOCAL REGISTRAR'S SIGNATURE <u>h</u>		24. FUNERAL DIRECTOR <u>Wm. J. Cons. 5305 Harbors Rd</u> ADDRESS	

970506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3445

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CORNEY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CORNEY</u>	
TOWN <u>CORNEY</u>		TOWN <u>CORNEY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Rd. Corney</u>		STREET ADDRESS (If rural give location) <u>Harford Rd. Corney MD.</u>	
3. NAME OF DECEASED (Type or Print) <u>Anne</u>	(First) <u>M.</u> (Middle) <u>Corney</u>	(Last)	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>30</u> (Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 9-1902</u>
9. AGE last birthday <u>48</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>	11. BIRTHPLACE (State or foreign country) <u>Cecil Co.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Wm G. Murray</u>	14. MOTHER'S MAIDEN NAME <u>Mary E. Murray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY No. <u>(If yes, give war or dates of service)</u>	17. INFORMANT <u>Mr. Robt. E. Corney, Harford Rd. Corney MD.</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### INTERVAL BETWEEN ONSET AND DEATH

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

#### 23. BURIAL, CREMATION REMOVAL (Specify)

#### DATE THEREOF

#### NAME OF CEMETERY OR CREMATORY

#### LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 4/20/51

REGISTRAR'S SIGNATURE A W Hedrick

24. FUNERAL DIRECTOR

ADDRESS

Lassahn Funeral Home 7401 Belair Rd.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3446

## CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Chromine Road</u>		STREET ADDRESS (If rural give location) <u>Chromine Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>MARGARET</u>	(First) <u>IRENE</u>	(Last) <u>CHALK</u>	4. DATE OF DEATH (Month) <u>APRIL</u> (Day) <u>12</u> (Year) <u>1951</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>May 17, 1859</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>91</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Keener</u>		14. MOTHER'S MAIDEN NAME <u>Susan Griffith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mrs. O. C. Bennett - Chromine Rd., Reisterstown</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) PULMONARY EDEMA

INTERVAL BETWEEN ONSET AND DEATH

48 HRS

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) ARTERIOSCLEROTIC - HYPERTENSIVE CARDIO VASCULAR DISEASE

2 YRS.

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒ (STATE)

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from JANUARY....., 1951/...., to APRIL....., 1951/...., that I last saw the deceased

alive on APRIL....., 1951/...., and that death occurred at 2:00 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Martin E. Strobel

M.D.

59 HANOVER RD. REISTERSTOWN

4/12/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Apr. 14, 1951</u>	<u>Greenmount Cem.</u>	<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/13/51</u>	<u>R. W. Hedrick</u>	<u>Thos. J. Sicker &amp; Sons - Balto., Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

3447

1. PLACE OF DEATH- COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Washington, D. C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines 16 Fusting Ave, Catonsville</u>		STREET ADDRESS (If rural, give location) <u>2219 Wisconsin Ave, N. W.</u>	
3. NAME OF DECEASED (First) <u>Aglae</u> (Middle) <u>Josephine</u> (Last) <u>Chamberlin</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>11</u> (Year) <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Apr 28, 1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>83</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>New Orleans, La.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Eugene Violland</u>		14. MOTHER'S MAIDEN NAME <u>Aglae Josephine Phiffer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Gao B. Chamberlin</u>	
17. INFORMANT AND ADDRESS <u>1300 Southview Road Baltimore, Md</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

## Immediate cause

(a) Myocardial Insufficiency1200

## Antecedent cause(s)

(b) Hypertensive Cardio-Vascular Disease1032

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Senility532

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct 10, 1950, to April 11, 1951, that I last saw the deceasedalive on April 10, 1951, and that death occurred at 12:20 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/13/51</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	LOCATION (City, town, or county) <u>Arlington, Va.</u>	(State)
APPROVED BY REG. <u>APR 11 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>W. H. Meadows &amp; Son</u>	ADDRESS <u>805 N. Calvert St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>103 Hilton Ave.</u>		STREET ADDRESS <u>103 Hilton Ave.</u> (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Clifford Warren Chapman</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>5</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 18, 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Professor of Pharmacology</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. of Md.</u>	9. AGE last birthday <u>54</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>London, Ontario</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>John Farmer Chapman</u>		14. MOTHER'S MAIDEN NAME <u>Minnie George</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mrs. Effie W. Chapman</u>		<u>103 Hilton Avenue Catonsville, Md.</u>	

### 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Coronary occlusion</u>	<u>few minutes</u>
Antecedent cause(s)	(b) <u>Coronary arterio-sclerosis</u>	<u>14 year</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug., 1940, to April 5, 1951, that I last saw the deceased alive on April 1, 1951, and that death occurred at 10:20 p.m., from the causes and on the date stated above.

SIGNATURE <u>Elmer L. Tol</u>		ADDRESS <u>20 E. Preston St., Balto., Md.</u>		DATE SIGNED
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4 - 9 - 51</u>	<u>Mount Pleasant</u>	<u>London, Ontario</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4-6-51</u>	<u>L</u>	<u>John O. Mitchell &amp; Sons, Inc.</u>	<u>1900 Eutaw Place Baltimore, Md.</u>	

3448  
30

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 18</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>428 20th Street</u>	
3. NAME OF DECEASED (Type or Print) <u>ROBERT</u> (First) <u>(MM)</u> (Middle) <u>CHAPMAN</u> (Last)		4. DATE OF DEATH <u>April 20</u> (Month) (Day) (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-25-00</u>
9. AGE last birthday <u>50</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Keethstree, S.C.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eddie Chapman</u>		14. MOTHER'S MAIDEN NAME <u>Annie Jane (MM) unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) BILATERAL PULMONARY ABSCESSSES

INTERVAL BETWEEN ONSET AND DEATH

UNKNOWN

##### Antecedent cause(s)

(b) LEFT CEREBRAL INFARCT

UNKNOWN

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☒ No ☐

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 26 1951, to April 20, 1951, and that I last saw the deceased alive on March 26, 1951 and that death occurred at 5:10 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

C. B. COPE, M. D.

VAH, FORT HOWARD, MARYLAND

4-21-51

#### 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/23/51

W. Hedrick

Mrs. Katie R. Williams

322 N. Schroder

St., Baltimore, Md.

500 836

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

3450

Reg. Dist. No. 35

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> TOWN <u>Parkville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> TOWN <u>Parkville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>E. Joppa Rd.</u>		STREET ADDRESS (If rural give location) <u>E. Joppa Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Raymond</u> (Middle) <u>Earl</u> (Last) <u>Chatman</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb. 5-1903</u>
9. AGE last birthday <u>48</u> yrs.		10. If under 1 year Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garage Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Lee Ray. Chatman</u>		14. MOTHER'S MAIDEN NAME <u>unk.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>192-05-6313</u>	
17. INFORMANT <u>Mrs. Raymond Chatman</u>		18. <u>E. Joppa Rd Balto</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause <u>Heart disease, coronary occlusion sudden</u>		<u>Sudden</u>	
(b) Antecedent cause(s) <u>Hypertension</u>		<u>Unknown</u>	
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Kollin b. Hudson M.D., D.M.E.</u>		DATE SIGNED <u>4/10/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/13/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Moreland M. Park Cem.</u>		LOCATION (City, town, or county) <u>Balto md</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>R. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Lassell Funeral Home 7401 Belair Rd.</u>	

550816

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3452

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Balts.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Balts.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York, Rd.</u>		STREET ADDRESS (If rural, give location) <u>York, Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>H.</u>	(Last) <u>Claiborne</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar. 22, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>mining</u>	9. AGE last birthday <u>69</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>218-01-9871</u>	
17. INFORMANT <u>Essie Watkins</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

6 days

Antecedent cause(s)

(b)

Cardio-renal-vascular disease, chronic

2 yrs

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

#### 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb., 1951, to April 26, 1951, that I last saw the deceased

alive on April 26, 1951, and that death occurred at 5:25 P.m., from the causes and on the date stated above.

SIGNATURE Rollin C. Hudson M.D. (Degree or title) ADDRESS Towson Md DATE SIGNED 4/26/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/29/51</u>	<u>Pleasant Rest</u>	<u>Towson, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>April 28-1951</u>	<u>P. H.</u>	<u>Wm. I. Chalmers Jr.</u>	<u>1701 M.E. Galloway St. Balt. Md.</u>	

820105

MARGIN RESERVED FOR BINDING

PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

3451

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Balto.</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kingston Park.</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kingston PK.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>176 Kingston Park.</u>				STREET ADDRESS (If rural, give location) <u>176 Kingston PK.</u>	
3. NAME OF DECEASED (Type or Print) <u>Thomas Francis Clancy.</u>		(First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>4/18/51</u> 19	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec. 9-1890</u>	9. AGE last birthday <u>60</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clark</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
13. FATHER'S NAME <u>James Clancy.</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Hinkson</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war of service) <u>no</u>		16. SOCIAL SECURITY No. <u>-</u>		17. INFORMANT AND ADDRESS <u>Josephine Clancy. (wife)</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Occlusion</u>		<u>10 min</u>
Antecedent cause(s) (b) <u>Chronic Myocarditis.</u>		<u>5 yrs.</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>W. Davis M.D. - Asst. Med. Exm.</u>		DATE SIGNED <u>4/19/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/21/51</u>	NAME OF CEMETERY OR CREMATORY <u>Sacred Heart.</u>	LOCATION (City, town, or county) (State) <u>Bethesda Md.</u>
DATE REC'D BY LOCAL REG. <u>4/19/51</u>	REGISTRAR'S SIGNATURE <u>L</u>	24. FUNERAL DIRECTOR <u>John J. Connelly.</u> ADDRESS <u>Essex 24</u> <u>2509 36 md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3453

Evidence for addition  
in 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

FILM No. G 132 APR 6 1951 FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>303 Thacker Ave</u>		STREET ADDRESS (If rural give location) <u>303 Thacker Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ADA</u> (Middle) <u>B.</u> (Last) <u>COSTER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 2, 1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Jan. 31, 1890</u>
9. AGE last birthday <u>61</u> yrs.		10. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pvt. Secy.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>215-01-5752</u>	
17. INFORMANT <u>Mr. C. L. Matthews - Ellicott City, Md.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<p>970.2 Immediate cause (a) <u>Suicide. Barbiturate poison, taking drug</u></p> <p>163B Antecedent cause(s) <u>Carbon monoxide from auto in garage</u></p> <p><u>Blood showed 50% of each (4/6/51 acc)</u></p> <p>(c) <u>Cause of death pending</u></p>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>April 2 1951 9-55 a.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u>See above</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Dr. M. K. Hoffman</u>		DATE SIGNED <u>April 2, 51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/3/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenmount Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md</u>	
DATE REC'D BY LOCAL REG. <u>4-3-51</u>		24. FUNERAL DIRECTOR <u>Wm. J. Tiekner &amp; Sons - Balto.</u>	
REGISTRAR'S SIGNATURE <u>JT</u>		ADDRESS <u>Balto.</u>	

350736

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

3454

Reg. Dist. No. 48

### 1. PLACE OF DEATH:

County Baltimore  
City or town Spansonia Point Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

newborn infants give residence of mother  
State Maryland County Baltimore  
City or town Spansonia Point  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1012 9th St  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mary Louise Crushaw

### 3. (b) Social Security Number

4. Sex F 5. Color or race col 6.(a) Single, married, single  
6.(b) Name of husband or wife  
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28th 1951

8. AGE: Years 19 Months — Days — If less than one day hrs. — min.

9. Birthplace Virginia  
(Town, county, and state)

10. Usual occupation Crushaw

11. Industry or business Rosemont Spansonia

12. Name va

13. Birthplace Alma Wynn

14. Maiden name va

15. Birthplace

16. Informant

Address Burial

17. (Burial, cremation, or removal, Which?) Burial Date thereof 4-17-51  
(month) (day) (year)

Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18. Funeral director Charles R. Law

Address 802 Madison Ave

19. (Date filed by registrar) 4/16/51 Registrar C. R. Law

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 15th 1951 at 1:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10th 1951 to April 15th 1951 and that I last saw him alive on April 15th 1951

Immediate cause of death Scarlet fever DURATION 5 days

Due to 490X

Due to 108

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Thomas MD

Address 10 W. Main St Date signed 4/15/51

MARGIN RESERVED FOR BINDING

VS A5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3455

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Ft. Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hos.</u>		STREET ADDRESS (If rural, give location) <u>2319 Eutaw Place</u>	
3. NAME OF DECEASED (First) <u>Arthur</u> (Middle) <u>(NMI)</u> (Last) <u>DAVIDSON</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>6/14/92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>furniture</u>	9. AGE last birthday <u>58</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Davidson</u>		14. MOTHER'S MAIDEN NAME <u>Adele P. Pollack</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY No. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Vet. Adm. Hosp. Clin. Records, Ft. Howard, Md.</u>			

### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) ARTERIOSCLEROTIC HEART DISEASE

Antecedent cause(s)

(b) CONGESTIVE HEART FAILURE

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March 17, 1951, to April 26, 1951, that I last saw the deceased

alive on March 19, 1951, and that death occurred at 8:40 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 29, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore Md</u>	(State)
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DATE REC'D BY LOCAL REG. <u>April 28 1951</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>	24. FUNERAL DIRECTOR <u>SOL LEVENSON &amp; Bros</u>	ADDRESS <u>1126 W. North Ave.</u>
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200658

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY CERTIFICATE OF DEATH

Registered No. **3458**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Louis Wohler*

2. DATE  
OF  
DEATH

*April 7th 51*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *King of Prussia Md*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *md* B. COUNTY *Balto. Co*

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Raspensburg*

c. Length of stay in Baltimore

*Life*

D. STREET ADDRESS (If rural, give location)  
*#401 King Ave*

5. SEX

*M*

6. COLOR OR RACE

*W*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*married*

8. DATE OF BIRTH

*Feb-26-1897*

9. AGE (In years last birthday)

*54*

10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Night Watchman Property Sales*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
*Balto. Co*

12. CITIZEN OF WHAT COUNTRY?  
*USA*

13. FATHER'S NAME

*Louis W. Wohler*

14. MOTHER'S MAIDEN NAME  
*Mary Hilner*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
*yes World War I*

16. SOCIAL SECURITY NO.  
*217-01-9999*

17. INFORMANT

ADDRESS

*Mrs Louis Wohler #401 King Ave Balto. Co md*

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

*Chronic myelogenous - leukemia*

INTERVAL BETWEEN ONSET AND DEATH

*6 yrs +*

204.1 ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

*740*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from *Aug -*, 19*50*, to *4-7-*, 19*51*, that I last saw the deceased alive on *4-7-*, 19*51*, and that death occurred at *P. m.*, from the causes and on the date stated above.

23A. SIGNATURE

*R. B. Ewson*

23B. ADDRESS

*7201 York Rd (Balt)*

23C. DATE SIGNED

*4-7-51*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*4/11/51*

24C. NAME OF CEMETERY OR CREMATORY

*Zion Luth Cem*

24D. LOCATION (City, town, or county)

*Balto. md*

DATE RECEIVED BY LOCAL REGISTRAR

*4/11/51*

REGISTRAR'S SIGNATURE

*L*

25. FUNERAL DIRECTOR

*Lanshin Funeral Home 7401 Balair Rd*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3457 38

1. PLACE OF DEATH- COUNTY <b>Balto.</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Md.</b> COUNTY <b>Balto.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Towson</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Towson</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>531 Regester Ave.</b>				STREET ADDRESS (If rural, give location) <b>531 Regester Ave</b>	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
<b>LOUIS</b>		<b>H.</b>		<b>DOST</b>	<b>April 18 1951</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>married</b>		8. DATE OF BIRTH <b>Feb. 12, 1872</b>	9. AGE last birthday <b>79 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Retail Grocery</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Grocery Bus.</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>Charles H. Dost</b>		14. MOTHER'S MAIDEN NAME <b>-- Hofmeister</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <b>Mrs. Ida M. Dost - 531 Regester Ave.</b>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) **Arteriosclerotic Heart Disease**INTERVAL BETWEEN  
ONSET AND DEATH**3 yrs.**

## Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(b) **Coronary Thrombosis****1948.**(c) **Thrombophlebitis Both Legs.****1948.**

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.**Infarction Lt. Lung****1951.**

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT (Specify) PLACE (Home, farm, factory, street,  
SUICIDE OF office bldg., etc.)  
HOMICIDE INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Not While  
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Mar. 25, 1951**, to **Apr. 18, 1951**, that I last saw the deceasedalive on **Apr. 18, 1951**, and that death occurred at **5:55 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Adelthine****M.D. 3105 N. Charles St.****4-19-51**23. BURIAL, CREMATION  
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

**4/19/51****A.W. Hedrick****Thm. J. Sickenet Sons - 290636 Balto Md**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



Items 8,11,13,14 per tele. call Mr. Norton 5/16/51. w.w.

MARYLAND STATE DEPARTMENT OF HEALTH

3458

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk-Turner Station</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Turners Station Dundalk</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>564 New Pittsburgh Ave.</b>		STREET ADDRESS (If rural, give location) <b>542 New Pittsburgh Ave.</b>	
3. NAME OF DECEASED (Type or Print) <b>GREGORY</b>	(First) (Middle) (Last)	4. DATE OF DEATH <b>April 24, 1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Infant</b>	8. DATE OF BIRTH <b>Feb. 12, 1951</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <b>1</b> yrs. <b>1</b> Months <b>1</b> Days <b>19</b> Hours <b>1</b> Min.
11. BIRTH PLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Jarvis Dry</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Dry</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mrs. John Mills, 542 New Pittsburgh Ave.</b>	
17. INFORMANT			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) **Lobar pneumonia**

Antecedent cause(s) (b) **490X 108**  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at work ☐ Not while at work ☐

(CITY OR TOWN) (COUNTY) (STATE) 20. AUTOPSY? Yes ☒ No ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

**Stanley B. Dunsen M.D.** 700 Fleet St., Baltimore 2, Md. April 25, 1951

23. BURIAL, CREMATION REMOVAL (Specify) **Burial** DATE THEREOF **Apr. 27, 1951** NAME OF CEMETERY OR CREMATORY **Mt. Auburn** LOCATION (City, town, or county) (State) **Baltimore, Md.**

DATE REC'D BY LOCAL REG. **7/25/51** REGISTRAR'S SIGNATURE **Alfred R. Law** 24. FUNERAL DIRECTOR ADDRESS **Charles R. Law, 802 Madison Ave.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

50-02681

VS. A15A



COPY SENT TO LOCAL REGISTRAR No. \_\_\_\_\_ DATE 4-23-57

RECEIVED

APR 23 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3460

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>439 N. Central Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>CLARENCE</u> (Middle) <u>(NMI)</u> (Last) <u>DUPREE</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-5-17</u>
9. AGE last birthday <u>34</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u> b. KIND OF BUSINESS OR INDUSTRY <u>Clauter House</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilson, S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Dupree</u>		14. MOTHER'S MAIDEN NAME <u>Julia Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war, or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>250-07-3931</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) NEPHROSIS, TOXIC

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) HEPATITIS, HOMOLOGOUS SERUM

5 weeks

(c) ANEMIA, ACQUIRED HEMOLYTIC

4 weeks

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 23 1951, to April 24 1951, that I saw the deceased

and that death occurred at 2:25 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 4-24-51

#### 23. BURIAL CREMATION REMOVAL (Specify)

#### DATE THEREOF

#### NAME OF CEMETERY OR CREMATORY

#### LOCATION (City, town, or county)

#### (State)

#### DATE REC'D BY LOCAL REG.

#### REGISTRAR'S SIGNATURE

#### 24. FUNERAL DIRECTOR

#### ADDRESS

4-29-1951

South Carolina

Elroy O. Wilson, 1000 Brantley Avenue Baltimore, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

3461

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middleriver</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middleriver</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>34 B. Westway North</u>		STREET ADDRESS (If rural, give location) <u>34 B. Westway North</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Barbara</u>	(Middle) <u>J.</u>	(Last) <u>Ellifritz</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Jan. 23. 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>2</u> yrs. <u>7</u> months <u>27</u> days
13. FATHER'S NAME <u>Earl E. Ellifritz</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <u>Mr Earl E. Ellifritz. (Father)</u>	
16. SOCIAL SECURITY No. <u>---</u>		14. MOTHER'S MAIDEN NAME <u>Edith M. Hyde</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Broncho-pneumonia-Bilateral</u>		<u>1 day</u>
Antecedent cause(s) (b) <u>Hydrocephalus.</u>		<u>Birth</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Spiral Bifida.</u>		<u>"</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dehydration</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Emm</u>	(CITY OR TOWN) <u>Balto</u> (COUNTY) <u>20</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 14, 1951, to Apr 19, 1951, that I last saw the deceased alive on Apr 18, 1951, and that death occurred at 2-20p m., from the causes and on the date stated above.

SIGNATURE John C. Baier M (Degree or title) ADDRESS 815 Eastern Ave. Emm Md DATE SIGNED 4-19-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>4/22/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Dryridge Cemetery</u>	LOCATION (City, town, or county) <u>Mannchoice.</u> (State) <u>Penna.</u>
DATE REC'D BY LOCAL REG <u>April 19, 1951</u>	REGISTRAR'S SIGNATURE <u>Edith M. Hyde</u>	24. FUNERAL DIRECTOR <u>John E. Hoff.</u>	ADDRESS <u>Chase. Md.</u>

120-1-23-1-33-3-404.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 23 1951  
BUREAU V. M.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3462

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>Dundalk</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>Dundalk</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>47 E. Stansbury Road.</b>		STREET ADDRESS (If rural, give location) <b>47 E. Stansbury Road.</b>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>CLARA S. ELLISON</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>April 12, 1951</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Mar. 17, 1867</b>
9. AGE last birthday <b>84 yrs.</b>		10. If under 1 year Months Days Hours Mins. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Lewis T. Hopkins</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. MacFarland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT AND ADDRESS <b>Mr Lewis A. Redford, 17 W. Cross St.</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) **Chronic Myocarditis**

## Antecedent cause(s)

(b) **Dementia**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## INTERVAL BETWEEN ONSET AND DEATH

**3 yrs.**

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Nov 28**, 19**45**, to **Apr. 12**, 19**51**, that I last saw the deceased alive on **Apr 11**, 19**51**, and that death occurred at **10:30 P.** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>4/16/51</b>	NAME OF CEMETERY OR CREMATORY <b>Mt Olivet</b>	LOCATION (City, town, or county) <b>Baltimore, Md.</b>	(State)
DATE REC'D BY LOCAL REG. <b>April 14-1951</b>		REGISTRAR'S SIGNATURE <b>R.W.</b>		24. FUNERAL DIRECTOR <b>Wm. Cook, Inc., 1217 So. Paul Street</b>	
				ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3463

# MARYLAND STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

### FOR MEDICAL EXAMINERS

Reg. Dist. No. XX

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>California</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Vet. Adm. Hosp., Ft. Howard, Md.</b>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <b>OTTO</b>	(Middle) <b>H.</b>	(Last) <b>FELDMAN</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1-20-12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Junk Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	9. AGE last birthday <b>39</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Woodbury Co., Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Oscar Feldman</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ghrannert</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY No. <b>Unknown</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **THROMBOSIS, BASILAR ARTERY****UNKNOWN**

Antecedent cause(s)

(b) **NONE**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. **INFARCT OF PONS****UNKNOWN**

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

**Howard Blight Funeral Home 6009 Harford Road, Baltimore 11, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

3464

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baynesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baynesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS —		STREET ADDRESS (If rural, give location) <u>1693 Wakona Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Elenore L. Fells</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 30, 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 11, 1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>89</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ind.</u>	
13. FATHER'S NAME <u>Israel T. Leacock</u>		14. MOTHER'S MAIDEN NAME <u>Wherry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. —	
17. INFORMANT AND ADDRESS <u>Foster Fells 3606 Marmon Ave</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral accident</u>		<u>2 days</u>
Antecedent cause(s) (b) <u>Generalized arterio-sclerosis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>83a</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/1, 1949, to 4/30, 1951, that I last saw the deceased alive on 4/20, 1951, and that death occurred at 8:20 P m., from the causes and on the date stated above.

SIGNATURE Gordon Dray MD ADDRESS 8543 John Road Bld DATE SIGNED 5/2/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 3/57</u>	<u>Lorraine Cemetery</u>	<u>Woodlawn Maryland</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>5/3/57</u>	<u>A W Heuser</u>	<u>Loring Byers</u>	<u>500 5th St. Bkts</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 25

3465

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>5525 Patrick Henry Drive</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>RUDOLPH</u> <u>O</u> <u>FETTERS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 7</u> <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>6-4-97</u>
9. AGE last birthday <u>53</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>janitor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	11. BIRTHPLACE (State or foreign country) <u>Clairfield, Co. Pa.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Daniel Feters</u>	
14. MOTHER'S MAIDEN NAME <u>Susanna Sullivan</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WW-1</u>	
16. SOCIAL SECURITY No. <u>168-09-7495</u>		17. INFORMANT AND ADDRESS <u>Clin. Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic Pyelonephritis, lt. kidney</u>	<u>5 yrs.</u>
Antecedent cause(s) (b) <u>Contracture of vesical neck</u>	<u>5 yrs plus</u>
(c) <u>Surgical absence of rt. kidney</u>	
2. OTHER SIGNIFICANT CONDITIONS	5 yrs.
Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	20. AUTOPSY?
19b. MAJOR FINDINGS OF OPERATION	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)
SUICIDE	INJURY
HOMICIDE	
TIME (Month) (Day) (Year) (Hour)	HOW DID INJURY OCCUR?
OF INJURY	While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>

22. I hereby certify that I attended the deceased from Mar. 17, 1951, to Apr. 7, 1951, that I last saw the deceased alive on and that death occurred at 8:15 A.M., from the causes and on the date stated above.

SIGNATURE [Signature] (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4-10-51</u>	NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>	LOCATION (City, town, or county) (State) <u>5501 Frederick Ave. Balto. Md.</u>
DATE REC'D BY LOCAL REG. <u>April 9, 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>McCully Funeral Home 3914 Hanover St. Balto.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

770 888

RECEIVED

APR 12 1941

BUREAU V. E.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3466-38

1. PLACE OF DEATH COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Towson Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2700 Joppa Road</u>		STREET ADDRESS (If rural give location) <u>2700 Joppa Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Sarah</u>	(Middle) <u>Ellen</u>	(Last) <u>Toard</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Sept. 19 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	9. AGE last birthday <u>81</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Bowie, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levis Henry Barron</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Parker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If year, give war or dates of service)		17. INFORMANT <u>Mrs. John H. Janssen</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u>
Immediate cause (a) <u>Arteriosclerotic Cardiovascular Renal Disease</u>			
Antecedent cause (s) <u>and hypertension</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>131a</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 10, 1943, to April 12, 1951, that I last saw the deceased alive on April 12, 1951, and that death occurred at 11.35 p.m., from the causes and on the date stated above.

SIGNATURE <u>[Signature]</u>	(Degree or title)	ADDRESS <u>6217 Harford Rd Baltimore</u>	DATE SIGNED <u>4/13/51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>Apr. 15 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Baker's Cem.</u>	LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>4-13-51</u>	REGISTRAR'S SIGNATURE <u>G. M. Barron</u>	24. FUNERAL DIRECTOR <u>R. Madison White</u>	ADDRESS <u>Harford Co. Md.</u>

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED  
APR 18 1955  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

3467

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write OR give nearest town) <u>Rural (Rural)</u> TOWN <u>70915</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Rural)</u> TOWN <u>70915</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Black Rock Road</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u> (Middle) <u>Newton</u> (Last) <u>Howble</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 6 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 3, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	9. AGE last birthday <u>73</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Hampstead, Md</u>
13. FATHER'S NAME <u>William Howble</u>	14. MOTHER'S MAIDEN NAME <u>Susan Etta Jones</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY No. <u>---</u>	17. INFORMANT AND ADDRESS <u>Miss Irene Howble - Hampstead, Md</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Coronary Thrombosis</u>	<u>1 day</u>
Antecedent cause(s)	(b) <u>Arteriosclerotic Heart Disease</u>	<u>4 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) <u>93d</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 31, 1951, to April 6, 1951, that I last saw the deceased alive on April 5, 1951, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

SIGNATURE W. H. Hoard ADDRESS M.D. Manchester, Md DATE SIGNED April 7-1951

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Apr 9/51</u>	NAME OF CEMETERY OR CREMATORY <u>Grace</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
DATE REC'D BY LOCAL REG. <u>4-8-51</u>	REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>	24. FUNERAL DIRECTOR <u>Edw R. Ypton</u>	ADDRESS <u>Hampstead</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

100105 274



RECEIVED

APR 16 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3/

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 7</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>OLD COURT RD</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 7</u> TOWN <u>Rosey</u> STREET ADDRESS (If rural, give location) <u>OLD COURT RD</u>	
3. NAME OF DECEASED (Type or Print) <u>JAMES</u> (First) <u>EDWARD</u> (Middle) <u>FRAZIER</u> (Last)		4. DATE OF DEATH <u>APRIL</u> (Month) <u>16</u> (Day) <u>1951</u> (Year)	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH <u>OCT. 13-1875</u>
9. AGE last birthday <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Engineer &amp; Henry Miller</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JOSEPH FRAZIER</u>		14. MOTHER'S MAIDEN NAME <u>JUSAN FRYFOGE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-03-1979</u>	
17. INFORMANT AND ADDRESS <u>MRS JAMES FRAZIER - WIFE</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) CORONARY OCCLUSION

INTERVAL BETWEEN ONSET AND DEATH

2 DAYS

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) CONGESTIVE HEART FAILURE2 WEEKS(c) HYPOSTATIC PNEUMONIA1 WEEK

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

CHRONIC NEPHRITIS2 YRS.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from MAR -, 1950, to APRIL 16, 1951, that I last saw the deceased alive on APRIL 16, 1951, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY	LOCATION (City, town, or county)	(State)
<u>Removal</u>		<u>4/19/51</u>	<u>Mt. Olive</u>	<u>Rosey</u>	<u>md.</u>
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>4/8/51</u>		<u>a.w. Redman</u>		<u>Wm. Cook, Inc., 1217 E. Paul St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

583 VVV

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

3469

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>GOVANS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>GOVANS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>407 SCHWARTZ AVE.</u>	
3. NAME OF DECEASED (Type or Print) <u>ROBERT R. GARRETT</u>		4. DATE OF DEATH <u>APR. 14, 1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>MAY 4, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDNER</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>57</u> yrs.
13. FATHER'S NAME <u>JAMES M. GARRETT</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY No.		14. MOTHER'S MAIDEN NAME <u>SOPHIE RENOLDS</u>	
17. INFORMANT <u>ELIZABETH C. GARRETT 407 SCHWARTZ AVE.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>THROMBOTIC OCCLUSION OF CORONARY ARTERY OF HEART</u>	<u>7 wks</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>MYOCARDIAL FAILURE</u>	<u>1 yr.</u>
	(c) <u>ARTERIO SCLEROTIC HEART DISEASE</u>	<u>5 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
<u>NONE</u>		
19a. DATE OF OPERATION <u>NONE</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NONE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 15, 1949, to APRIL 14, 1951, that I last saw the deceased alive on APRIL 14, 1951, and that death occurred at 4:10 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Apr. 15, 1951</u>	<u>Arbutus Mem. Pk.</u>	<u>Baltimore Co. Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4/17/51</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>1631 Druid Hill Ave.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3470 4x

<b>1. PLACE OF DEATH:</b> County..... <u>Baltimore</u> City or town..... <u>Sparrows Point</u> <small>(If outside city or town limits, write RURAL and give nearest town)</small> How long in above place of death?..... <u>10 years</u> Hospital, institution, or street address where death occurred:..... How long in hospital or institution?.....		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> <small>(For newborn infants give residence of mother)</small> State..... <u>Maryland</u> County..... <u>Baltimore</u> City or town..... <u>Sparrows Point</u> <small>(If outside city or town limits, write RURAL and give nearest town)</small> Street No..... <u>718 5th Street</u> <small>(If rural, give LOCATION)</small> 2.(a) If veteran, name war.....	
<b>3. (a) FULL NAME</b> <u>Sandy William Bodsey</u>		<b>3. (b) Social Security Number</b> <u>213-09-2320</u>	
<b>4. Sex</b> <u>M</u>	<b>5. Color or race</b> <u>col</u>	<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>	
<b>6. (b) Name of husband or wife</b> <u>Minish Bodsey</u>			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>Aug. 31-1898</u>			
<b>8. AGE:</b> Years <u>54</u> Months _____ Days _____ If less than one day _____ hrs. _____ min.			
<b>9. Birthplace</b> <u>Keyville Va.</u> <small>(Town, county, and state)</small>			
<b>10. Usual occupation</b> <u>Fireman</u>			
<b>11. Industry or business</b> <u>Baltimore Steel Co.</u>			
FATHER	<b>12. Name</b> <u>Wm. Bodsey</u>		
	<b>13. Birthplace</b> <u>Va.</u>		
MOTHER	<b>14. Maiden name</b> <u>Ida P.</u>		
	<b>15. Birthplace</b> <u>Va.</u>		
<b>16. Informant</b> <u>Minish Bodsey</u> Address <u>718 N. St. Sparrows Pt. Md.</u>			
<b>17. Removal</b> (Burial, cremation, or removal. Which?) <u>Removal</u> Date thereof <u>April 25, 1951</u> <small>(month) (day) (year)</small> Cemetery or crematory <u>St. Ellis Cemetery</u> Location <u>Keyville Va.</u>			
<b>18. Funeral director</b> <u>Samuel W. Sullivan Jr.</u> Address <u>1011 N. Arlington Ave. Balto.</u>			
<b>19.</b> <u>4/23</u> 19 <u>51</u> <u>W. Bodsey</u> (Date recorded by registrar) Registrar			
<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> <u>April 22nd</u> 19 <u>51</u> at <u>10A</u> M <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>January 4th</u> to <u>April 22nd</u> and that I last saw him alive on <u>April 21st</u> 19 <u>51</u> <b>Immediate cause of death</b> <u>Acute poisoning</u> <b>DURATION</b> <u>1 month</u> <b>Due to</b> <u>Chronic Intestinal Nephritis</u> <b>Due to</b> <u>Hypertension and</u> <u>Arterio Sclerosis</u> <b>Other conditions</b> <u>406x</u> <u>131a</u> <small>(Include pregnancy within 3 months of death)</small> <b>Major findings of operations</b> Date of op. _____ <b>Autopsy results</b> <b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically. <b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) (County) (State) Injured at home, farm, industry, public place (where?) _____ Manner of injury _____ Injured at work? _____ <b>23. SIGNATURE</b> <u>W. Bodsey M.D.</u> Address <u>1077 N. Main St. Annapolis Md.</u> Date signed <u>4/23/51</u>			

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3471

1. PLACE OF DEATH- COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Towson</b>		LENGTH OF STAY (in this place) <b>4 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Towson</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>204 Maryland Avenue</b>				STREET ADDRESS <b>204 Maryland Avenue</b>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) <b>EDWARD</b>		(First) <b>GINTER</b>		(Middle) <b>GOOD</b>		(Last)	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widower</b>		8. DATE OF BIRTH <b>August 18, 1869</b>	
				9. AGE last birthday <b>81</b> yrs.		4. DATE (Month) (Day) (Year) OF DEATH <b>April 24, 1951</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telegraph Operator- Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Good</b>		14. MOTHER'S MAIDEN NAME <b>? Ginter</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY No. <b>None</b>	
				17. INFORMANT AND ADDRESS <b>Fred L. Good, 204 Maryland Ave., Towson, Md.</b>			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

**Hemiplegia - Cerebral Hemorrhage -**INTERVAL BETWEEN  
ONSET AND DEATH**4 weeks**

Antecedent cause(s)

(b)

**Arteriosclerosis****4 years**Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not  
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Work ☐ Not While  
At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July**, 19**46** to **24 Apr**, 19**51**, that I last saw the deceasedalive on **24 Apr**, 19**51**, and that death occurred at **11 A**.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Charles H. Keis****M.D.****6201 York Rd****Baltimore, Md****24 Apr 51**23. BURIAL, CREMATION  
REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

**4/24/51****Dr. H. Hedrick****John Burns' Sons, Towson, Maryland**

VD 2

365506

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

3472

1. PLACE OF DEATH  
 County..... Baltimore  
 City or town..... Halethorpe  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 yrs  
 Hospital, institution, or street address where death occurred:  
3429 Washington Blvd  
 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... MD County..... Baltimore  
 City or town..... Halethorpe  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3429 Washington Blvd  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

Margaret B. Grace

## 3. (b) Social Security Number

4. Sex..... Female  
 5. Color or race..... white  
 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... John J.  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) 6/17/1892  
 8. AGE: Years..... 58 Months..... 10 Days..... 9  
 If less than one day..... hrs. .... min.

9. Birthplace..... Baltimore Md.  
 (Town, county, and state)  
 10. Usual occupation..... House wife  
 11. Industry or business..... at home  
 12. Name..... Michael D. Seller  
 13. Birthplace..... Baltimore Md.  
 14. Maiden name..... Anna Regina Michler  
 15. Birthplace..... Baltimore Md.

16. Informant..... Mr. John J. Grace  
 Address..... 3429 Washington Blvd.  
 17. Burial  
 (Burial, cremation, or removal, Which?) Date thereof..... 4/30/51  
 (month) (day) (year)  
 Cemetery or crematory..... Meadowridge Mem. Pk.  
 Location..... Washington Rd Dorsey Md.  
 18. Funeral director..... John J. Gowan & Son  
 Address..... 9011 Hollins St.

19. 4/27 19 51 R.W. Reduch  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 4/26/ 19 51, at 8 A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 19 49 to April 19 51  
 and that I last saw h.e. alive on Apr. 1-25 19 51  
 Immediate cause of death..... Hypertensive - Atherosclerosis  
Cardiovascular Disease  
 DURATION  
 Due to..... 443X  
 Due to..... 93d  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?.....  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... R. Suber  
 M. D. or other  
 Address..... 1945 W. B. St.  
 Date signed..... 4/26/51



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

3473

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>38 Mellor Ave.</u>		STREET ADDRESS (If rural, give location) <u>38 Mellor Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>WILLIAM WESLEY GREENWELL</u>		4. DATE OF DEATH <u>APR 14</u> , 19 <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOW, DIVORCED <u>Widower</u>	8. DATE OF BIRTH <u>9/12/88</u>
9. AGE last birthday <u>62</u> yrs.		10. UNDER 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing Contractor - Self emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Clay Greenwell</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Howard</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, and if unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Mrs. James F. S. Westervelt, Catonsville</u>	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Coronary Occlusion

## Antecedent cause(s)

(b)

Coronary Sclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

## 20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1928, to April 14, 1951, that I last saw the deceased alive on April 14, 1951, and that death occurred at 10:30 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 4/16/51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

574246

RECEIVED  
JUN 19 1964  
BUREAU V.E.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Anne Arundel</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		LENGTH OF STAY OR (in this place) <b>3 Mo.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Solley</b> ( <b>Glen Burnie, Md. P.O.</b> )	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>The Opitz Home</b>				STREET ADDRESS (If rural, give location) <b>(Rural)</b>	
3. NAME OF DECEASED (First) <b>Herman</b> (Middle) <b>Gunther</b> (Last) <b>Gunther</b>		4. DATE OF DEATH (Month) <b>April</b> (Day) <b>6</b> (Year) <b>1951</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 28, 1877</b>	9. AGE last birthday <b>73</b> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Master ship joiner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USCG Curtis Bay</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>None</b>		17. INFORMANT AND ADDRESS <b>Solley Mrs. Josephine Gunther, Glen Burnie, Md.</b>	
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
<p>2384 Immediate cause (a) <b>Left Hemiplegia</b></p> <p>83d Antecedent cause(s) (b) <b>Hypertension, Atherosclerosis</b></p> <p>(c)</p>					<b>3 mo.</b>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <b>No</b> SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>1/23</b> , 19 <b>51</b> , to <b>4/6</b> , 19 <b>51</b> , that I last saw the deceased alive on <b>4/5</b> , 19 <b>51</b> , and that death occurred at <b>3:30 A.m.</b> , from the causes and on the date stated above.					
SIGNATURE <b>J. Lloyd Johnson</b>		(Degree or title)		ADDRESS <b>Catonsville</b> DATE SIGNED <b>4/6/51</b>	
23. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>April</b>		NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b> LOCATION (City, town, or county) <b>Dorsey</b> (State) <b>Md.</b>	
DATE REC'D BY LOCAL REG. <b>4-6-51</b>		REGISTRAR'S SIGNATURE <b>V.E. Harry</b>		24. FUNERAL DIRECTOR ADDRESS <b>Thomas W. Singleton, Glen Burnie, Md.</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

478

3474

Reg. Dist. No. 30

510916



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3475

Reg. Dist. No. 31

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RANDALLSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RANDALLSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>LIBERTY Rd</u>		STREET ADDRESS (If rural give location) <u>LIBERTY Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Catherine</u> (First) <u>Haddigan</u> (Middle) <u></u> (Last)		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>26</u> (Year) <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE last birthday <u>81</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10h. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT <u>John J. McGuire</u>		<u>Randallstown Md.</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

#### Immediate cause

(a)

#### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from....., 1957, to 4/26, 1957, that I last saw the deceased

alive on 4/25, 1957, and that death occurred at 10:02 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>4/30/57</u>	<u>ST. PETERS</u>	<u>BALTO. Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/27/57</u>	<u>Wm E. Martin</u>	<u>M. Fayer-Sons</u>	<u>401 Suffolk Rd-18.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 8 1951  
BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

3476

Reg. Dist. No. 30

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> TOWN <u>Catonsville</u> STREET ADDRESS (If rural give location) <u>376 A Northpoint Road</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>ROY</u> (Middle) <u>CLINE</u> (Last) <u>HALL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April</u> <u>10</u> , 19 <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 18, 1918</u>
9. AGE last birthday <u>32</u> yrs. <u>8</u> Months <u>23</u> Days		10. BIRTHPLACE (State or foreign country) <u>Weston, West Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>Weston, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harvey John Hall</u>		14. MOTHER'S MAIDEN NAME <u>Lula K. Wetzel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>102</u>	
17. INFORMANT <u>Hospital Records, Catonsville 28, Maryland</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>Immediate cause</u> <u>420.1 Antecedent cause(s)</u> <u>94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		(b) <u>acute Coronary Insufficiency</u>	
(c) <u>Autopsy finding</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Dr. S. McKie</u>		DATE SIGNED <u>April 11, 51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb. 13, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>West Newton Cem.</u>		LOCATION (City, town, or county) (State) <u>Weston, West Virginia</u>	
DATE REC'D BY LOCAL REG. <u>4-11-51</u>		REGISTRAR'S SIGNATURE <u>T. E. Harry</u>	
24. FUNERAL DIRECTOR <u>J. W. McCauley</u>		ADDRESS <u>West Newton, Penna.</u>	

513336

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED

APR 16 1951

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 21 on: Item 7  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

3477

Reg. Dist. No. *48*

1. PLACE OF DEATH- COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Sparrows Point</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Bethlehem Steel Co.</b>		STREET ADDRESS (If rural, give location) <b>437 Folcroft Street</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>PHILLIP</b>	(Middle) <b>CLARKE</b>	(Last) <b>HAMMOND</b>
4. DATE OF DEATH	(Month) <b>April</b>	(Day) <b>30</b>	(Year) <b>1951</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH <b>6-7-1916</b>
9. AGE last birthday <b>34</b> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CADET LINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BETH STEEL CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES HAMMOND</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH FOX</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <b>213-09-4120</b>	
17. INFORMANT <b>MARIE F. HAMMOND</b>		<b>437 S. FOLCROFT ST.</b>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) <b>Immediate cause</b> <b>Carbon monoxide poisoning</b>			
(b) <b>Antecedent cause(s)</b> <b>892.3 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</b> <b>178C</b>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg, etc.) <b>Industrial place</b>	
(CITY OR TOWN) <b>Bethlehem Steel Co., Sparrows Point, Md.</b>		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) INJURY <b>4/30/51</b> <b>A.m.</b>		INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <b>Blast from furnace gas (5/15/51 akc)</b>			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <i>William J. Lovett</i>		DATE SIGNED <b>April 30, 1951</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		DATE THEREOF <b>5-4-51</b>	
NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>		LOCATION (City, town, or county) (State) <b>4701 GERMAN HILL RD. MD.</b>	
DATE REC'D BY LOCAL REG. <b>5/3/51</b>		24. FUNERAL DIRECTOR <b>Charles S. Giller</b>	
REGISTRAR'S SIGNATURE <i>a.w. Hensch</i>		ADDRESS <b>901 S. CONKLING ST. BALTO., MD</b>	

970 336

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural (Cato nsville)</u> LENGTH OF STAY (in this place) <u>1 1/2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital Baltimore 28</u>		STREET ADDRESS (If rural, give location) <u>3404 Chesnut Avenue</u>	
3. NAME OF DECEASED (First) <u>HARRY</u> (Middle) <u>(H)</u> (Last) <u>HANSEN</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 29 1951</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>July 10, 1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newsboy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Street vendor</u>	9. AGE last birthday <u>43</u> yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wallace Hansen</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Olsen</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr. Waldo Hansen (bro.) Baltimore</u>		838 W/ 34th St.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cardiac decompensation</u>			<u>6 wks</u>
Antecedent cause(s) (b) <u>Cardiovascular &amp; renal disease</u>			<u>2 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Mental deficiency</u>			<u>life</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<u>none</u>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>none</u>	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Sept. 11, 1936, to Apr. 29, 1951, that I last saw the deceased alive on Apr. 29, 1951, and that death occurred at 6:50 A. m., from the causes and on the date stated above.

SIGNATURE Gertie J. Fleichmann M.D. ADDRESS Spring Grove State Hospital Baltimore 28, Md. DATE SIGNED Apr. 29, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>5/2/51</u>	NAME OF CEMETERY OR CREMATORY <u>Barthwood</u>	LOCATION (City, town, or county) (State) <u>Baltimore</u>
DATE REC'D BY LOCAL REG. <u>5/1/51</u>	REGISTRAR'S SIGNATURE <u>A W Hedrick</u>	24. FUNERAL DIRECTOR <u>Paul E. Chesnut</u>	ADDRESS <u>3615-17 Chestnut Ave</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

460 459

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *44*

3479

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>519 N. Paca Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>SAMUEL</u> (Middle) <u>(NMI)</u> (Last) <u>HARDEN</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1-6-90</u>
9. AGE last birthday <u>61</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Elenton, North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Harden</u>	
14. MOTHER'S MAIDEN NAME <u>Martha MN: Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) HYPERTENSIVE CARDIOVASCULAR DISEASE

UNKNOWN

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

MYOCARDIAL INFARCTION WITH MURAL THROMBOSIS

UNKNOWN

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

(OLD)

#### 20. AUTOPSY?

Yes ☒ No ☐

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 25, 1951, to April 27, 1951, that I last saw the deceased

live on April 27, 1951 and that death occurred at 9:15 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

V. O. EARECKSON, M. D.

VAH, FORT HOWARD, MARYLAND

4-28-51

#### 23. BURIAL, CREMATION REMOVAL (Specify)

#### DATE THEREOF

#### NAME OF CEMETERY OR CREMATORY

#### LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG.

REGISTRAR'S SIGNATURE

#### 24. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 918 Druid Hill Ave. Baltimore, Maryland

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK.

770 VVV

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change  
in 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

3480

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 13</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>3013 Kentucky Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CHARLES R. HARE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 4 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-10-75</u>
9. AGE last birthday <u>75</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>SAW</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>CARDIAC DILATATION AND HYPERTROPHY</u>		<u>Unknown</u>	
Antecedent cause(s) (b) <u>PULMONARY EDEMA</u>		<u>Unknown</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>CORONARY ARTERIOSCLEROSIS WITH MYOCARDIAL SCARRING</u>		<u>13</u>	
<u>68</u> days		<u>68</u> days	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office hldg., etc.) INJURY <u>Home</u>	(CITY OR TOWN) <u>B.C.</u>	(COUNTY) <u>B.C.</u>
TIME (Month) <u>April</u> (Day) <u>4</u> (Hour) <u>7 PM</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fell getting into wheel chair</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Walter M Carmine M.D.</u>		DATE SIGNED <u>4-4-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4-6-51</u>	NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG. <u>4-6-51</u>	REGISTRAR'S SIGNATURE <u>LL</u>	24. FUNERAL DIRECTOR <u>Jos. J. Herr &amp; Sons, 3001 Kentucky Ave. Balto.</u>	

510 506



## MARYLAND. STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3481

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6 YORK ROAD</u>		STREET ADDRESS (If rural, give location) <u>6 YORK ROAD</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOSEPH</u>	(Middle) <u>GRASON</u>	(Last) <u>HARTLEY</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 14, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE VICE PRESIDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANK</u>	9. AGE last birthday <u>60</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH H. HARTLEY</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH EMMART</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY No. <u>215-16-6326</u>	
17. INFORMANT AND ADDRESS <u>MRS. J. GRASON HARTLEY - 6 YORK RD. TOWSON, MD.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Coronary Thrombosis</u>		<u>2 hrs.</u>
(b) Antecedent cause(s) <u>Coronary Sclerosis</u>		<u>20 years</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) <u>TOWSON</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	(COUNTY) <u>Balt.</u>
HOW DID INJURY OCCUR?		(STATE) <u>md.</u>

22. I hereby certify that I attended the deceased from Dec., 1938, to 6 Apr., 1951, that I last saw the deceased alive on 6 Apr., 1951, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

SIGNATURE Robert H. Quinn M.D. ADDRESS 4 York Rd. Towson Balt. Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>APRIL 9, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEMETERY</u>	LOCATION (City, town, or county) <u>TOWSON, BALTO. CO. MD.</u>
DATE REC'D BY LOCAL REG. <u>4-9-51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>JOHN BURNS' SONS</u>	ADDRESS <u>TOWSON, MD.</u>

290 716

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

348230  
Reg. Dist. No.

1. PLACE OF DEATH COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Catonsville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Ruxton</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>The Pines Nursing Home Rusting Ave.</b>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <b>George</b>	(First) (Middle) <b>Helfrich</b>	(Last)	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	4. DATE OF DEATH <b>April 22, 1951</b>
8. DATE OF BIRTH <b>April 23, 1907</b>		9. AGE last birthday <b>43</b> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Life Ins.</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore County, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Samuel H. Helfrich</b>	
14. MOTHER'S MAIDEN NAME <b>Edith Benson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT <b>Samuel H. Helfrich-106 W. University Parkway</b>	

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <b>Pulmonary abscess - Retro splenic abscess</b>		<b>Months -</b>	
Antecedent cause(s) (b) <b>Pancreatitis</b>		<b>Years -</b>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Ruptured Gastric Ulcer -</b>		<b>Years ago.</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <b>Feb 1 - 1951</b>		19b. MAJOR FINDINGS OF OPERATION <b>Abscess under dome of liver - involving Gall bladder</b>	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>April 19, 1951</b> , to <b>April 22, 1951</b> , that I last saw the deceased alive on <b>April 22, 1951</b> , and that death occurred at <b>1:45 p.m.</b> , from the causes and on the date stated above.			
SIGNATURE <b>Wm. Edgar Ford</b>		ADDRESS <b>20 E. Preston St.</b>	
DATE SIGNED <b>4 - 23 - 51</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>4 - 24 - 51</b>	NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>
24. FUNERAL DIRECTOR <b>John O. Mitchell &amp; Sons, Inc.</b>	ADDRESS <b>1900 Eutaw Place Baltimore, Md.</b>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

3483

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7519 Long St</u>		STREET ADDRESS (If rural, give location) <u>7519 Long Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Barbara Sue</u> (Middle) <u>M</u> (Last) <u>Henderson</u>	DATE OF DEATH April 11 <sup>th</sup> 1951	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11/9/47</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>3</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Henderson</u>		14. MOTHER'S MAIDEN NAME <u>Marie Logre</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>James Henderson, 7519 Long St</u>			

18. MEDICAL CERTIFICATION		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
754.4 Immediate cause (a) <u>Congenital Heart Disease</u>		<u>3 yrs</u>
157e Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>M. J. Davis M.D.</u>	(Degree or title)	ADDRESS <u>Syrup Exam. &amp; Indus. Bldg. 4/11/51</u>	DATE SIGNED <u>4/11/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>4/14/51</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	LOCATION (City, town, or county) (State) <u>Baltimore, MD</u>
DATE REC'D BY LOCAL REG. <u>4/12/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hadzicki</u>	24. FUNERAL DIRECTOR <u>M. Cook</u>	ADDRESS <u>1217 St Paul St</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Balto.</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mercy Villa Bellona Ave.</u>				STREET ADDRESS (If rural, give location) <u>6300 Blenheim Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>ROSA</u>		(First) <u>MARIE</u>		(Last) <u>HILGENBERG</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr.</u> <u>15</u> <u>19 51</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Apr. 17, 1872</u>		9. AGE last birthday <u>78</u> yrs. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>Seidt</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mrs. Pauline Kraus - 6300 Blenheim Rd.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

1940

## Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Chronic Int. Nephritis, Chronic Myocarditis1945

(c)

Acute Cardiac Dehiscence1951

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Bayer's Disease1949

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 3, 1940, to July 15, 1951, that I last saw the deceasedalive on April 15, 1951, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

G. H. BishopA.B.-M.D.503 Shandon Rd4/16/5723. BURIAL, CREMATION  
REMOVAL (Specify)

## DATE TIME OF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

Burial4/18/51Oak Lawn Cem.Balto., Md.DATE REC'D BY LOCAL  
REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

4/17/57A. W. HedrickChas. J. Fickner & Sons - Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3485

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Clarabelle Stephens HORNER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 1 1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>March 30, 1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>85</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Henry HORNER</u>		14. MOTHER'S MAIDEN NAME <u>Hannah E. DANNEKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital Record; Spring Grove Hospital</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Right lower lobar pneumonia</u>		<u>4 days</u>
Antecedent cause(s) (b) <u>Arteriosclerotic CV dis.</u>		<u>indef</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>fungus dermatitis of feet</u>		<u>indef</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-6-1932, 19....., to 4-1-1951, 19....., that I last saw the deceased alive on 3-31-1951, 19....., and that death occurred at 6 A.m., from the causes and on the date stated above.

SIGNATURE Abraham M. Schneidmuhl (Print name or title) ADDRESS Spring Grove Hospital DATE SIGNED April 1, 1951

Abraham M. Schneidmuhl M. D. Baltimore Md.

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 4-3-1951 NAME OF CEMETERY OR CREMATORY Mt. Olivet LOCATION (City, town, or county) Baltimore (State) Md.

DATE REC'D BY LOCAL REG. 4/2/51 REGISTRAR'S SIGNATURE a w [signature] 24. FUNERAL DIRECTOR G. Howard Strong ADDRESS 3207W. North Ave.,

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *33*

1. PLACE OF DEATH COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Owings Mills</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Rosewood State Training School</i>		STREET ADDRESS (If rural give location) <i>719 Hanover</i>	
3. NAME OF DECEASED (First) <i>Raymond</i> (Middle) (Last) <i>Horwitz</i>		4. DATE OF DEATH (Month) <i>April</i> (Day) <i>23</i> (Year) <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>1-2-22</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>29</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Joseph Horwitz</i>		14. MOTHER'S MAIDEN NAME <i>Yetta Shavitz</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <i>Hospital Records</i>			

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause <i>753.1</i> <i>157d</i> <i>Antecedent cause(s)</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(a) <i>Broncho-pneumonia</i>	INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
(b) <i>Spastic Diplegia</i>		<i>Cong.</i>
(c) <i>Microcephaly &amp; mental deficiency</i>		<i>Cong.</i>

#### 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *Apr. 20*, 19*57*, to *Apr. 23*, 19*57*, that I last saw the deceased

alive on *4-23*, 19*57*, and that death occurred at *12:30 A* m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

*Viola Barrett Johns, M.D. Rosewood, Owings Mills, Md 4-23-57*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>April 24, 1957</i>	<i>Anshei Emunah Cong Cemetery</i>	<i>Baltimore</i>	<i>Md</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>4/23/57</i>	<i>Alfred J. Smith</i>	<i>Edgar Swenson &amp; Son</i>	<i>1126 W North Ave</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Presbyterian Home</u>		STREET ADDRESS (If rural give location) <u>517 ORKNEY Road</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Elizabeth Warder Janney</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 30, 1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>March 5, 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>87</u> yrs.
13. FATHER'S NAME <u>William W. Janney</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>		17. INFORMANT <u>Records, Presbyterian Home, Towson, Md.</u>	
16. SOCIAL SECURITY No. <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
14. MOTHER'S MAIDEN NAME <u>Marion Dean</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>443X Antecedent cause(s)</u> <u>93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		(a) <u>Myocardial Decompensation</u> (b) <u>Arterio Sclerosis + Hypertension</u> (c)		<u>2 yrs</u> <u>sub</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 16, 1951</u> , to <u>April 30, 1951</u> , that I last saw the deceased alive on <u>April 30, 1951</u> , and that death occurred at <u>10:30 P</u> m., from the causes and on the date stated above.					
SIGNATURE <u>John O. Mitchell</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>28 Allegheny Ave., Towson, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>5 - 3 / 51</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	
LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		24. FUNERAL DIRECTOR <u>John O. Mitchell &amp; Sons, Inc.</u>		ADDRESS <u>1900 Eutaw Place</u>	
DATE REC'D BY LOCAL REG. <u>5/2/51</u>		REGISTRAR'S SIGNATURE <u>a.w. Hedrick</u>		ADDRESS <u>Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3488

Reg. Dist. No. 38

1. PLACE OF DEATH - COUNTY <b>Baltimore</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>111 Allegheny Avenue</b>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <b>Maryland</b> COUNTY <b>Baltimore</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> TOWN STREET ADDRESS (If rural, give location) <b>111 Allegheny Avenue</b>	
3. NAME OF DECEASED (First) <b>DANIEL</b> (Middle) <b>of St. THOMAS</b> (Last) <b>JENIFER</b>		4. DATE OF DEATH (Month) <b>April</b> (Day) <b>30</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 11, 1883</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doctor of Medicine</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Practise</b>	9. AGE last birthday <b>67</b> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas R. Jenifer</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ann Moore</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT AND ADDRESS <b>H. Courtney Jenifer, Towson, Maryland</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <b>Acute myocardial infarction</b>		<b>2 days</b>
Antecedent cause(s) (b) <b>Previous myocardial disease</b>		<b>years</b>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Arteriosclerotic heart disease</b>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Generalized debilitation</b>		<b>years</b>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <b>SUICIDE</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>3/23</b> , 19 <b>51</b> , to <b>4/30</b> , 19 <b>51</b> , that I last saw the deceased alive on <b>4/30</b> , 19 <b>51</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.		
SIGNATURE <b>Donald L. Somerville M.D.</b> (Degree or title)		ADDRESS <b>25 W. Pa. Ave. Towson 4, Md.</b> DATE SIGNED <b>4/30/51</b>
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>May 2, 1951</b>	NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b> LOCATION (City, town, or county) <b>Towson, Maryland</b> (State)
DATE REC'D BY LOCAL REG. <b>5/1/51</b>	REGISTRAR'S SIGNATURE <b>A. W. Hedrick</b>	24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b> ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

075868

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DELLA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DELLA</u>	
TOWN <u>DELLA</u>		TOWN <u>DELLA</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>DELLA AVE BOX 35</u>		STREET ADDRESS (If rural, give location) <u>DELLA AVE BOX 35</u>	
3. NAME OF DECEASED (Type or Print) <u>ALFRED</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>3-10-1874</u>	
9. AGE last birthday <u>77</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BEALE JONES</u>		14. MOTHER'S MAIDEN NAME <u>HOLLAND</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT <u>SUMMERFIELD JONES DELLA, MD.</u>			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Arteriosclerotic Cardiovascular Disease

## Antecedent cause(s)

(b) 4 angina of the right foot - arteriosclerotic(c) stating the underlying cause lastII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>		(CITY OR TOWN)		(COUNTY)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from Dec, 1950, to April 6, 1951, that I last saw the deceased alive on April 6, 1951, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>4-10-1951</u>		NAME OF CEMETERY OR CREMATORY <u>Family Pl.</u>		LOCATION (City, town, or county) <u>DELLA, MD.</u>		(State)	
DATE REC'D BY LOCAL REG. <u>4-9-51</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>1631 Druid Hill Ave.</u>			

MARGIN RESERVED FOR BINDING

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Fort Howard</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Vet. Adm. Hosp., Ft. Howard, Md.</b>		STREET ADDRESS (If rural, give location) <b>1412 Division Street</b>	
3. NAME OF DECEASED (Type or Print) <b>JAMES</b> (First) <b>D.</b> (Middle) <b>JONES</b> (Last)		4. DATE OF DEATH (Month) <b>April</b> (Day) <b>12</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>2-2-92</b>
9. AGE last birthday <b>59</b> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Danville, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ellis Jones</b>		14. MOTHER'S MAIDEN NAME <b>Zura MN: Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY No. <b>Unknown 217 89</b>	
17. INFORMANT AND ADDRESS <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

522X Immediate cause (a) **PULMONARY EDEMA**

UNKNOWN

45a Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(b) **NONE**

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

HISTORY OF OPERATION FOR CARCINOMA OF THE LIP

19a. DATE OF OPERATION <b>12-28-50</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of the lip</b>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Dec. 14**, 19**50**, to **April 12**, 19**51**, and that death occurred at **5:45 P.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**JOSEPH M. MILLER, M. D., CHIEF, SURGICAL SERVICE, VAH, FORT HOWARD, MD. 4-13-51**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>4/16/51</b>		NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
--	--	--------------------------------	--	--	--	--	--

DATE REC'D BY LOCAL REG. <b>April 14, 1951</b>		REGISTRAR'S SIGNATURE <b>R.W.</b>		24. FUNERAL DIRECTOR <b>Charles R. Law</b>		ADDRESS <b>802 Madison Avenue</b>	
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Baltimore 1, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

3491

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 17</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>746 W. North Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>PATRICK</u>	(Middle) <u>JOSEPH</u>	(Last) <u>KEARNEY</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>4</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2-23-91</u>
9. AGE last birthday <u>60</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk.</u>	
11. BIRTHPLACE (State or foreign country) <u>Minoka, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Kearney</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hagen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW I</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

### 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>BILATERAL CEREBRAL HEMORRHAGE</u>	<u>UNKNOWN</u>
Antecedent cause(s) (b) <u>331X 83a</u> Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last	
(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<u>PERIARTERITIS NODOSA</u>	<u>UNKNOWN</u>
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 14, 1950, to April 4, 1951, that I last saw the deceased

XXXXXXXXXXXXXXXX and that death occurred at 4:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Irving Freeman, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 4-5-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>4/5/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Cemetery</u>	LOCATION (City, town, or county) (State) <u>Scranton, Pennsylvania</u>
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DATE REC'D BY LOCAL REG. <u>4-5-51</u>	REGISTRAR'S SIGNATURE <u>G. M. Bacon</u>	24. FUNERAL DIRECTOR <u>Howard Blight Funeral Home 6009 Harford Road, Baltimore, Md.</u>
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SHIP TO: Frank Eagen Funeral Home 2908 Birney Ave., Scranton, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15







# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3492

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u></u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ivy Hall Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>7920 Shirely Ave.</u>	
3. NAME OF DECEASED (First) <u>SUSANNA</u> (Middle) <u>M.</u> (Last) <u>C. KELLUM</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept 10, 1875</u>
9. AGE last birthday <u>75</u> yrs.		10. AGE last birthday (If under 1 year Months. Days Hours Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Frank Debelius</u>		14. MOTHER'S MAIDEN NAME <u></u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT <u>Mrs. Frances Unger 2421 E. Fayette St.,</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>(a) Cerebro-Vascular accident</u>			<u>4-18-51</u>
Antecedent cause(s) <u>(b) Arterio-Sclerotic Cordis-Vasculum Primine</u>			<u>2 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>(c)</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 4-18, 1951, to 4-21, 1951, that I last saw the deceased alive on 4-21, 1951, and that death occurred at 8 A m., from the causes and on the date stated above.

SIGNATURE M. B. Bingham M.D. ADDRESS Balto 6 Md DATE SIGNED 4-21-51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE April 24, 1951 NAME OF CEMETERY OR CREMATORY Holy Redeemer LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REG. 4/24/51 REGISTRAR'S SIGNATURE H. W. Hedrick 24. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 2008 Orleans St.,

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>695 Gladstone Avenue</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>JEANETTE</u> <u>KINNAIRD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 22 19 51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>12-5-1887</u>
9. AGE last birthday <u>63</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Raphael Alexander Kinnaird</u>		14. MOTHER'S MAIDEN NAME <u>Jeanette A. Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital Records, Catonsville, Md.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Lympho-epithelioma, left tonsillar region

Interval BETWEEN ONSET AND DEATH  
Unknown

Antecedent cause(s)

(b) Metastases to left supraclavicular region

Unknown

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c) Cachexia

6 months

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED OF INJURY m. While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 14, 1950, to April 22, 1951, that I last saw the deceased

alive on April 22, 1951, and that death occurred at 11:15 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Florence Deringer Joyce M.D. Spring Grove State Hospital  
Catonsville 28, Maryland

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/24/51 Gallagher Gallagher 1214 Row 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3494 30

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Fusting Ave. House in the Pines</u>		STREET ADDRESS (If rural, give location) <u>1511 Park Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>AMELIA</u>	(Middle) <u>M.</u>	(Last) <u>KIRWAN</u>
4. SEX <u>female</u>	5. COLOR OR RACE <u>white</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	7. DATE OF BIRTH <u>Jan. 27, 1866</u>
8. AGE last birthday <u>85</u> yrs.	9. DATE OF DEATH <u>April 23, 1951</u>	10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	11. CITIZEN OF WHAT COUNTRY? <u>USA</u>
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		13. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
14. FATHER'S NAME <u>Michael Miller</u>		15. MOTHER'S MAIDEN NAME <u>J.</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. SOCIAL SECURITY NO. <u>no</u>	
18. INFORMANT AND ADDRESS <u>Mrs. J. Dallas Kirwan - 1511 Park Ave. Balto. 17, Md.</u>		19. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>904.0 Bronchopneumonia</u>			
(b) Antecedent cause(s) <u>1860 Fracture of Right Femur</u>			
(c) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>3/24/51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Fracture of Right Femur - Closed Reduction of Fracture</u>	
20. ACCIDENT SUICIDE HOMICIDE <u>accident</u>		21. PLACE (Home, farm, factory, street, office bldg., etc.) <u>Balto. City?</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>March 22, 1951 m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Fell down in her Room</u>		22. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>1/23</u> , 19 <u>51</u> , to <u>3/23</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>3/22/51</u> , 19 <u>51</u> , and that death occurred at <u>8:10 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Seymour Goldberg</u>		ADDRESS <u>1422 Park Ave</u>	
DATE SIGNED <u>4/24/51</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/25/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REG. <u>4/24/51</u>		REGISTRAR'S SIGNATURE <u>Wm. J. Tucker</u>	
FUNERAL DIRECTOR <u>Wm. J. Tucker &amp; Sons</u>		ADDRESS <u>Balto. Md.</u>	

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3495

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Angeline</u> (First) <u>O</u> (Middle) <u>Knight</u> (Last)		4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 24, 1867</u>
9. AGE last birthday <u>83</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Aberdeen Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	13. FATHER'S NAME <u>Alfred Greenland</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>	16. SOCIAL SECURITY No. <u>None</u>	17. INFORMANT AND ADDRESS <u>Roy Knight, Brooklyn Md</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Cerebral hemorrhage</u>	<u>5 days</u>
Antecedent cause(s)	(b) <u>hypertensive arterial sclerotic heart disease</u>	<u>Years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) <u>420.0 93d</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
OF INJURY		

22. I hereby certify that I attended the deceased from April 4, 1951, to April 7, 1951, that I last saw the deceased alive on April 7, 1951, and that death occurred at 7:10 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Ed O Hodous M.D. ADDRESS Edgewood Md DATE SIGNED 4-7-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 10, 1951</u>	<u>Salem</u>	<u>Happy Falls, Baltimore</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>April 11 - 51</u>	<u>C. E. Arthur</u>	<u>Howard R. McCombs &amp; Son</u>	<u>Abingdon Md</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 3 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3496 41

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2907 Page Drive</u>		STREET ADDRESS (If rural, give location) <u>2907 Page Drive</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>P.</u>	(Last) <u>Knighton</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>6,</u>	(Year) <u>19 51</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Jan. 31, 1869</u>
9. AGE last birthday <u>82</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John T. Knighton</u>		14. MOTHER'S MAIDEN NAME <u>Margaret A. Pentz</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>John A. Knighton, 1509 N. Rose Street</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Coronary occlusion

## Antecedent cause(s)

(b) Coronary arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## INTERVAL BETWEEN ONSET AND DEATH

Immediate at least 1 yearII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to —, 19—, that I last saw the deceasedalive on June, 1950, and that death occurred at 5 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1217 St. Paul Street

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

763-857



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3497

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>8320 Beryl Road</b>				STREET ADDRESS <b>8320 Beryl Road</b>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) <b>E. HILDA KOLLER</b>		(First) (Middle) (Last)		4. DATE OF DEATH <b>April 9, 1951</b>		(Month) (Day) (Year)	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 7, 1904</b>	9. AGE last birthday <b>46</b> yrs.	If under 1 year Months Days Hours Min.		If under 24 hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Thiel</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Schmidt</b>			
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <b>Elmer C. Koller, 8320 Beryl Road</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

**Uremia**

## Antecedent cause(s)

(b)

**Carcinoma of Sigmoid**Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(c)

INTERVAL BETWEEN  
ONSET AND DEATH**3 mos****1 year**

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF  
INJURYINJURY OCCURRED  
While at Not While  
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **April 1, 1950**, to **April 9, 1951**, that I last saw the deceasedalive on **April 9, 1951**, and that death occurred at **5:20 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION  
REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

**APR 11 1951**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

3498

Reg. Dist. No. 33

1. PLACE OF DEATH- COUNTY <i>Balts.</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Ind.</i> COUNTY <i>Balts.</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Reisterstown</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Dover Rd.</i>		STREET ADDRESS (If rural, give location) <i>Dover Rd.</i>	
3. NAME OF DECEASED (Type or Print) <i>Peter</i> (First) <i>KORMAN</i> (Middle) (Last)		4. DATE OF DEATH <i>Apr 16 1951</i> (Month) (Day) (Year)	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>married</i>	8. DATE OF BIRTH <i>Oct 19, 1869</i>
9. AGE last birthday <i>81</i> yrs.		10. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i>	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no.</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <i>none.</i>	
17. INFORMANT AND ADDRESS <i>Mrs Rosa Korman (wife)</i>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>arteriosclerotic C-V. Disease</i>			<i>1 yr.</i>
Antecedent cause(s) (b) <i>422.1 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</i>			
(c) <i>Cancer</i>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Contused face &amp; Lacerated Scalp.</i>			<i>1 1/2 hr.</i>
19a. DATE OF OPERATION <i>none.</i>	19b. MAJOR FINDINGS OF OPERATION <i>none.</i>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) <i>Barn on Farm</i>	(CITY OR TOWN) <i>Reisterstown</i> (COUNTY) <i>Balts.</i> (STATE) <i>Ind.</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>Apr 16 '51 3:30 p.m.</i>		INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <i>Deceased Fell &amp; struck face on barn door.</i>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <i>D. D. Caples, M.D. 24. Ind.</i>		ADDRESS <i>Reisterstown, Ind.</i> DATE SIGNED <i>4-17-'51</i>	
23. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>April 18-51</i>	NAME OF CEMETERY OR CREMATORY <i>Pleasant Grove</i> LOCATION (City, town, or county) <i>Baltimore Co.</i> (State)	
DATE REC'D BY LOCAL REG. <i>4-17-51</i>	REGISTRAR'S SIGNATURE <i>Mary B. E. Line</i>	24. FUNERAL DIRECTOR <i>Edw. C. Tipton Hampstead, Md.</i> ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

100105

RECEIVED  
JUN 1 1961  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3499

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rosedale</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rosedale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>913 Rosedale Ave.</u>		STREET ADDRESS (If rural give location) <u>913 Rosedale Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Florence E. Larduskey</u>	4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 22, 1875</u>
9. AGE last birthday <u>75</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Mail clerk)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas E. Larduskey</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. Mead</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-----</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY No. <u>-----</u>	
17. INFORMANT <u>Mrs George F. Garrison</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Cerebro-Vascular accident

INTERVAL BETWEEN ONSET AND DEATH

April 1/51

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic Cardio-Vascular disease 2 yrs

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hemiplegia

4 yrs

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☐

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY

INJURY OCCURRED  
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1951, to April 3, 1951, that I last saw the deceased

alive on April 3, 1951, and that death occurred at 6:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

#### 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/5/51

Edw Hedrick

John A. Moran 3000 E. Balto. St.

390578

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

3500

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>26ppereco</u> COUNTY <u>Baldw.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Joseph</u> (First) <u>Le Brun</u> (Last)		4. DATE OF DEATH <u>Apr 29</u> 19 <u>50</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct 15</u> 19 <u>71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>road work</u>	9. AGE last birthday <u>79</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>not known</u>		14. MOTHER'S MAIDEN NAME <u>not known</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Edora Dietz</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Chronic Myocarditis

## INTERVAL BETWEEN ONSET AND DEATH

5 yrs

## Antecedent cause(s)

422.1 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterio-Sclerosis20 yrs

93d

(c) Constipation (Chronic)1 week

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Apr 29, 1950., to Apr 29, 1950., that I last saw the deceased alive on Apr 29, 1950., and that death occurred at 6 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 15</u>		<u>St Pauls</u>		<u>Baldw</u> <u>Ind</u>	
DATE REC'D BY LOCAL REG. <u>4-29-51</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		24. FUNERAL DIRECTOR <u>Edw C. Tipton</u>		ADDRESS <u>Newport</u>	

970 646 Ind

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

REC-11  
MAY 3 1951  
BUREAU W. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change  
in 8 shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3591

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

FILM No. G 152 APR 16 1951

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Balto. Co</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>English Consul</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2819 Rose Ave. English Consul</u>		STREET ADDRESS (If rural, give location) <u>2819. Rose Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles.</u>	(Middle) <u>H</u>	(Last) <u>Leistner</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 19, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	<u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Farm</u>	9. AGE last birthday/ <u>75 yrs.</u>
11. BIRTHPLACE (State or foreign country)	<u>Balto. City</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	14. MOTHER'S MAIDEN NAME <u>Augusta Mintz</u>		
13. FATHER'S NAME <u>John. Leistner</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY No. <u>---</u>	17. INFORMANT AND ADDRESS <u>English Consul</u> <u>Mrs. Chas. H. Leistner, 2819 Rose Ave. Baltaco</u>		

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

MYELOID LEUKEMIA

INTERVAL BETWEEN  
ONSET AND DEATH

1 YR

Antecedent cause(s)

(h)

Disease or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY

m.

INJURY OCCURRED  
While at Not Whilo  
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY 12, 1950, to APRIL 8, 1951, that I last saw the deceased

alive on APRIL 7, 1951, and that death occurred at 8:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

#### 23. BURIAL, CREMATION REMOVAL (Specify)

#### DATE THEREOF

#### NAME OF CEMETERY OR CREMATORY

#### LOCATION (City, town, or county)

#### (State)

DATE REC'D BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

APR 9 1951

H

Jerusalem Funeral Home 7401 Belin Rd. Baltaco Md.

100105

2411 Washington Blvd. Little Rock

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3502

Reg. Dist. No. 20

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Md.</b> COUNTY <b>Balto.</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Catonsville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>444 Greenlow Road</b>		STREET ADDRESS (If rural, give location) <b>444 Greenlow Rd</b>	
3. NAME OF DECEASED (First) <b>Stephen</b> (Middle) <b>Michael</b> (Last) <b>Liberto</b>	4. DATE OF DEATH (Month) <b>April</b> (Day) <b>26</b> (Year) <b>51</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Oct. 28/50</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <b>6</b> yrs. If under 1 year <b>6</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Salvadore Liberto</b>		14. MOTHER'S MAIDEN NAME <b>Frances Brocato</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>1572</b>	
17. INFORMANT AND ADDRESS <b>Mr. Salvadore Liberto, 444 Greenlow</b>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

**Congenital Heart Disease**

INTERVAL BETWEEN ONSET AND DEATH

**Birth**

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

**- Pneumonia**

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <b>SUICIDE</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN) <b>Balto</b> (COUNTY) <b>Md</b> (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **April 17, 1951**, to **April 26, 1951**, that I last saw the deceasedalive on **April 16, 1951**, and that death occurred at **7:36 p.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Wm M. Liberto****M.D.****5402 Edmondson****4-27-51**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>April 28/51</b>	NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)
DATE REC'D BY LOCAL REG. <b>4/27/51</b>	REGISTRAR'S SIGNATURE <b>Wm. H. H. H. H. H.</b>	24. FUNERAL DIRECTOR <b>Wm. H. H. H. H.</b>	ADDRESS <b>4101 Edmondson Ave.</b>

2-00-28-0-24-1-40.4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

#50-2353

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*John Lilly*

2. DATE  
OF  
DEATH

*Apr. 8, 1951*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*Glenn L. Martin*

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

*MIDDLE RIVER*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Balto.*

D. STREET ADDRESS (If rural, give location)

*2502 Jefferson St.*

C. Length of stay in Baltimore

*4 mos.*

Yrs.  
Mos.  
Days

5. SEX

*male*

6. COLOR OR RACE

*white*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*married*

8. DATE OF BIRTH

*Oct. 2-1908*

9. AGE (In years last birthday)

*42*

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Electrician*

10B. KIND OF BUSINESS OR INDUSTRY

*Glenn L. Martin*

11. BIRTHPLACE (State or foreign country)

*W. Virginia*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*J. Harney Lilly*

14. MOTHER'S MAIDEN NAME

*Mary Massey*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Hattie M. Lilly 2502 Jefferson St.*

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

*Electrocution*

(A)

DUE TO

ANTECEDENT CAUSES

(B)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

*Industrial place*

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

*Glenn L. Martin Co.*

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

*April 8, 1951*

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

*Electrocuted while working on an electric switch.*

22. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*William W. Boyd*

23B. CHIEF MEDICAL EXAMINER... ASSISTANT MEDICAL EXAMINER... MEDICAL INVESTIGATOR

23C. DATE SIGNED

*Apr. 8, 1951*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Removal*

24B. DATE

*4/17/51*

24C. NAME OF CEMETERY OR CREMATORY

*Princeton*

24D. LOCATION (City, town, or county)

*Princeton W. Va.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*APR 9-1951*

25. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BIT

ERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH U.S. Every item of information should be carefully supplied. The correct age is especially important. Please write the causes of death clearly and legibly.

A15

V3. A15

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: Baltimore  
 County Woodlawn  
 City or town 40 years  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred  
2013 Englewood Avenue  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Woodlawn  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2013 Englewood Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME JULIA ANN O'BRYAN LINE 3. (b) Social Security Number

4. Sex FEMALE 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife William Line

7. Birth date of deceased (mo., day, yr.) September 27, 1881 6. (c) If alive, give age 40 years

8. AGE: Years 69 Months 7 Days 9 If less than one day  
 hrs. min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business George O'Bryan

12. Name George O'Bryan

13. Birthplace Unknown 443X

14. Maiden name Rose Rexrode 6

15. Birthplace Unknown

16. Informant Mrs Lillian Mullineaux

Address 6844 Dogwood Rd. Woodlawn, Md.

17. Burial Date Mailed April 10, 1951  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Woodlawn Cemetery

Location Woodlawn, Md.

18. Funeral director W. L. Amoreaux

Address 4510 Liberty Heights Ave.

19. 4-8-51 19 51  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1951 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9, 1948 to April 6, 1951  
 and that I last saw him alive on April 6, 1951

Immediate cause of death Uremia DURATION 3 mos

Due to Hypertensive cardio 10 years

vascular disease

Due to Arteriosclerotic cardio 10 years

vascular disease

Other conditions Diabetes mellitus 10 years

Coronary Thrombosis 6 mos  
 (Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William T. Traub, M.D. M.D. or other

Address 3400 Woodbine Ave. Balt. 7 Md. Date signed 4/6/51

Registrar



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middle River</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Box 367 Henrietta Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ivy Crest Home</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>CONSTANCE</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 11, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>73</u> yrs.
13. FATHER'S NAME <u>John S</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT <u>CONSTANCE TAAKOZA</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331x Immediate cause (a) <u>Ventricular Fibrillation</u>		<u>10 MINS.</u>
83a Antecedent cause(s) (b) <u>Cerebral Hemorrhage</u>		<u>90 MINS.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertensive Vascular Disease</u>		<u>10 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis; Osteoarthritis</u>		<u>9 yrs.</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/15, 1951, to 4/1, 1951, that I last saw the deceased alive on 4/1, 1951, and that death occurred at 2:30 P.m., from the causes and on the date stated above.

SIGNATURE D. Jay Blod, M.D. ADDRESS 434 Eastern Ave. #21 DATE SIGNED 4/1/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>April 4, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	LOCATION (City, town, or county) (State) <u>Belair Rd. Balto Md.</u>
DATE REC'D BY LOCAL REG. <u>4/3/51</u>	REGISTRAR'S SIGNATURE <u>A W Hedrick</u>	24. FUNERAL DIRECTOR <u>Joseph T. ...</u>	ADDRESS <u>430 ...</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

3506

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RANDALLSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RANDALLSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>DEER PARK RD</u>		STREET ADDRESS (If rural, give location) <u>DEER PARK RD</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOHN</u>	(Middle) <u>ELZEY</u>	(Last) <u>MATHER</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>SEPT. 21-1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESTONER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	11. BIRTHPLACE (State or foreign country) <u>MELVILLE - BALTO CO.</u>
13. FATHER'S NAME <u>NATHAN C. MATHER</u>		14. MOTHER'S MAIDEN NAME <u>EMMA BRISCOE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-14-7262</u>	17. INFORMANT AND ADDRESS <u>MRS JOHN MATHER - WIFE</u>

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) CONGESTIVE HEART FAILURE

INTERVAL BETWEEN ONSET AND DEATH

2 MOS.

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) BRONCHIAL ASTHMA15 YRS.(c) BRONCHIECTASIS CHRONIC3 YRS

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from SEPT. 1950, to APRIL 11, 1951, that I last saw the deceased alive on APRIL 11, 1951, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Thomas E. Wheeler MD Randallstown Md - 4-11-51  
APRIL 14, 1951 Cathedral Cemetery Baltimore, Md.  
8/13/51 R. W. Hedges Vernon Lemon, 4611 Park Hgts. Balto. Md.

573 246

# CERTIFICATE OF DEATH

Registered No. 3507

BIRTH NO.

1. NAME OF DECEASED (Type or Print) *Baltimore County*  
*Wiktmina (Minnie) A Meyers.*

2. DATE OF DEATH *April 19, 1951*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland *1738 Redwood Ave.*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *Baltimore, Md.*

B. FULL NAME OF HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*809 Cator Avenue*

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days  
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
*Nicholas H. Meyers 809 Cator Ave.*

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Hypostatic pneumonia*

*24 hours*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO  
(B) *Hypertensive cardiovascular disease*

*8 years*

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

DUE TO  
(C) *Chronic parenchymatous nephritis*  
*Diabetes at least*

*10 years*  
*10 years*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *August 14, 1950*, to *April 19, 1951*, that I last saw the deceased alive on *April 19, 1951* and that death occurred at *8:45 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*April 21, 1951*

*R.W.*

*Wm Cook, Inc. 1217 St. Paul St.*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3508

## CERTIFICATE OF DEATH

Reg. Dist. No. *1*

1. PLACE OF DEATH- COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Md</i>		COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Halethorpe</i>		LENGTH OF STAY (in this place) <i>25 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Halethorpe</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1776 Winans</i>				STREET ADDRESS <i>1736 Winans Ave</i>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)		
<i>Estelle</i>			<i>Michael</i>		<i>Apr 29 1951</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>		8. DATE OF BIRTH <i>Feb 22 1873</i>	9. AGE last birthday <i>78 yrs.</i>		10. If under 1 year Months Days Hours Mfn.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore City</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert Thos. Forsyth</i>				14. MOTHER'S MAIDEN NAME <i>Harriet Ann Howard</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT AND ADDRESS <i>Walter W. Marshall 4414 Maple Rd Baltimore 27 Md</i>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <i>Phlebotomy with</i>						<i>30 da</i>	
Antecedent cause(s) (b) <i>Chronic Hemiplegia</i>						<i>30 da</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>General arteriosclerosis</i>						<i>10 yrs</i>	
<i>Cerebral hyperextension</i>						<i>15 yrs</i>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <i>Diabetes Mellitus mild</i>						<i>9 mos</i>	
19a. DATE OF OPERATION <i>none</i>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb 13 1951</i> , to <i>Apr 29 1951</i> , that I last saw the deceased alive on <i>Apr 29 1951</i> , and that death occurred at <i>12 30</i> m., from the causes and on the date stated above.							
SIGNATURE <i>B B Cunningham</i>				ADDRESS <i>1609 Main St Elkins 27 Md</i>		DATE SIGNED <i>4/29/51</i>	
23. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>5/2/51</i>		NAME OF CEMETERY OR CREMATORY <i>Louisa Park Cem.</i>		LOCATION (City, town, or county) (State) <i>Balto., Md.</i>	
DATE REC'D BY LOCAL REG. <i>4/30/51</i>		REGISTRAR'S SIGNATURE <i>A W Hume</i>		24. FUNERAL DIRECTOR <i>Wm. J. Dickner &amp; Son</i>		ADDRESS <i>Balto. Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH: <u>Baltimore</u> COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: <u>Baltimore</u> STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Reisterstown</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Pleasant Sanatorium</u>		STREET ADDRESS <u>3849 Boardman Ave</u>	
3. NAME OF DECEASED (First) <u>HYMAN</u> (Middle) <u>MILLER</u> (Last) <u>MILLER</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 7, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Safe Cab. Co.</u>	11. PLACE (State or foreign country) <u>Lithuania</u>
13. FATHER'S NAME <u>Morris Miller</u>		14. MOTHER'S MAIDEN NAME <u>Tillie Krotzass</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-03-4275</u>	
17. INFORMANT <u>no</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
Immediate cause (a) <u>Pulmonary Hemorrhage</u>			
Antecedent cause(s) (b) <u>Pulmonary Tuberculosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from January 26, 1947, to April 4, 1951, that I last saw the deceased alive on April 4, 1951, and that death occurred at 5:20 p.m. from the causes and on the date stated above.

SIGNATURE Dr. Cecil Rudner (Degree or title) M.D. ADDRESS Mt. Pleasant Sanatorium, Reisterstown, Md. DATE SIGNED April 4, 1951

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE April 5, 1951 NAME OF CEMETERY OR CREMATORY Workmen Circle Cemetery LOCATION (City, town, or county) Baltimore Md (State)

DATE REC'D BY LOCAL REG. 4/5/51 REGISTRAR'S SIGNATURE a. J. Redrock 24. FUNERAL DIRECTOR Sol L. Lerman ADDRESS 1126 W North Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 35104

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Race. Rd # 193</u>		STREET ADDRESS (If rural, give location) <u>Race. Rd. # 193, Balto 21</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>A</u>	(Last) <u>Miller</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 11 - 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN. Farm.</u>	9. AGE last birthday <u>62 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Balto. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Eva. Schultz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Mrs. J. A. Miller, Race. Rd. Balto 21</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary occlusion</u>		<u>Sudden</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Cardio-Vascular disease</u>		<u>1 yr.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Stricture esophagus &amp; Stomach due to ingestion of Potash</u>		<u>1 1/2 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1951, to April 23, 1951, that I last saw the deceased alive on April 23, 1951, and that death occurred at 2 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/26/51</u>	<u>St. Joseph. Cem.</u>	<u>Baltimore Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4/23/51</u>	<u>H. W. Hadwick</u>	<u>Lassahn Funeral Home</u>	<u>7401 Belair Rd.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

3511

2411 N. Charles Street, Baltimore

Items 1, 9 on:

FILE No. G 132 MAY 14 1951

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Upper Falls</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>Bradshaw Md</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Annie</u> (Middle) <u>Laurie</u> (Last) <u>Monmonier</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 24 - 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chore</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>81</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Henry Harrison</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Sarah Stewart</u>	
16. SOCIAL SECURITY No. <u>-</u>		17. INFORMANT <u>Rev Ches B. Monmonier</u>	

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Rupture of aortic aneurism</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Myocardial and arterial sclerosis; generalized vascular sclerosis</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		(c) <u>Scurbous Carcinoma of left breast</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 13, 1948, to April 20, 1951, that I last saw the deceased alive on April 18, 1951, and that death occurred at 3:20 P m., from the causes and on the date stated above.

SIGNATURE John F. Noguera, M.D. - Kingsville, Md. DATE SIGNED 4/20/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>April 23-51</u>	<u>St Stephens Ch Cem</u>	<u>Bradshaw Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>April 21-1951</u>	<u>C. E. Arthur D. L.</u>	<u>C. E. Arthur</u>	<u>Fork Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAY 3

1952

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3512

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>anna</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>McKeesport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wayne Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>Amol</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Belie M. Morrison</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 8 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan 29 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS or INDUSTRY <u>Housework</u>	9. AGE last birthday <u>58</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm R Morrison</u>		14. MOTHER'S MAIDEN NAME <u>Mary E Powell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>148 Madison 46844</u>	
17. INFORMANT AND ADDRESS <u>Charles Morrison</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X Immediate cause

(a) Cerebral thrombosis

932 Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) due to hypertensive and arteriosclerotic cardio-vascular disease

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 13 Mar, 1951, to 8 April, 1951, that I last saw the deceased alive on 8 April, 1951, and that death occurred at 9<sup>35</sup> A. M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>4/10/51</u>	<u>Stonon Church</u>	<u>Stonon Township Pa</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>APR 9 1951</u>	<u>L</u>	<u>Wm H. Inc</u>	<u>12145 Stony 780826</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3513

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>none</u> TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARTIN</u> <u>MORRISON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 29, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Dec. 25, 1888</u>
9. AGE last birthday <u>62</u> yrs.		10. If under 1 year Months Days Hours Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laundry worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>laundry</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jerome (Unknown)</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Morrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records- Catonsville 28, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute cardio-respiratory failure

INTERVAL BETWEEN ONSET AND DEATH

1 hour

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Chronic myocarditisOver 2 yrs.(c) Chronic interstitial nephritisOver 2 yrs.

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Fracture of the neck of the right femur1 month

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT (Specify)

SUICIDE

HOMICIDE

Accident

## PLACE (Home, farm, factory, street, OF office bldg., etc.)

INJURY Spring Grove State Hospital

## (CITY OR TOWN)

## (COUNTY)

## (STATE)

TIME (Month) (Day) (Year) (Hour)

OF INJURY Mar 28, 1951 m.

INJURY OCCURRED

While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

Patient slipped and fell to the floor22. I hereby certify that I attended the deceased from Mar. 28, 1951, to April 29, 1951, that I last saw the deceasedalive on April 29, 1951, and that death occurred at 9:00 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

Spring Grove State Hospital

DATE SIGNED

M.D. Catonsville 28, Maryland5-1-51

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

## (State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

*Phil B. Hermann-Brown*  
 DATE: 5/2/51  
 ADDRESS: Spring Grove State Hospital  
M.D. Catonsville 28, Maryland

Harvard Med School  
Baltimore, Md

Frances A. Hensley  
578 N. Biddle St

643 846

RECEIVED  
MAY 3 1951  
BUREAU W. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **33**

3514

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Owings Mills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood State Training School</u>		STREET ADDRESS (If rural give location) <u>106 So. Carey Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Geraldine</u> (First) <u>Lynn</u> (Middle) <u>Mulholland</u> (Last)		4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>9</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>8-20-50</u>
9. AGE last birthday <u>7</u> yrs. <u>21</u> Months <u>1</u> Days		10. BIRTHPLACE (State or foreign country) <u>Maryland - A.A. Co.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Thomas Mulholland</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Helen Jones Platyke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>Institution Records</u>	
17. INFORMANT <u>Rosewood State Training School</u>			

### 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Communicating Hydrocephalus</u>	<u>Congen.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Arnold-Chiari Syndrome</u>	<u>Congen.</u>
	(c) <u>Spina Bifida &amp; Meningocele (Repaired)</u>	<u>Congen.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 28....., 1950., to Apr. 9....., 1951., that I last saw the deceased alive on Apr. 9....., 1951., and that death occurred at 11:40 P......m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George C. Medaury M. D. Owings Mills, Md 4/10/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/12/51</u>	NAME OF CEMETERY OR CREMATORY <u>Law &amp; Cathedral Cem</u>	LOCATION (City, town, or county) (State) <u>4700 Old Road Rd.</u>
DATE RECEIVED BY REG. <u>APR 11 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>901 Baltimore St.</u>

208200243404

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

La. 4131 7.10.

Margaret Walter - first father  
1849 W. Pratt St.

Ed. 13935

Birth Cert.  
or file in 8/10/18  
or file in 8/10/18



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Woodlawn</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodlawn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2018 Englewood Ave.</u>		STREET ADDRESS (If rural, give location) <u>2018 Englewood Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOHN</u>	(Middle) <u>ANTHONY</u>	(Last) <u>NEEB</u>
4. DATE OF DEATH	(Month) <u>Apr.</u>	(Day) <u>17</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 6, 1911</u>
9. AGE last birthday <u>39</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>John Neeb</u>		14. MOTHER'S MAIDEN NAME <u>Rose D'Antoni</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mrs. Mary A. Neeb - 2018 Englewood Ave.</u>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

Hodgkins Disease (Lymphatic Anaemia)

INTERVAL BETWEEN ONSET AND DEATH

1948

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Chronic myeloiditis1950

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 28, 1950, to Apr. 17, 1951, that I last saw the deceasedalive on Apr. 16, 1951, and that death occurred at 8 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Paul E. Brown M.D.3602 D. St. N.E. Ave.4/18/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/21/51</u>	NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>	LOCATION (City, town, or county) <u>Woodlawn, Md.</u>
DATE REC'D BY LOCAL REG. <u>4/19/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrich</u>	24. FUNERAL DIRECTOR, <u>Wm. J. Lickner</u>	ADDRESS <u>Baltimore</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

Registered No. 3516

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>CHARLES ALBRECHT NELSON</b>			2. DATE OF DEATH <b>April 3, 1951</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2645 Purnell Drive</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>2645 Purnell Drive</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>May 6, 1904</b>		9. AGE (In years last birthday) <b>46</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Social Security</b>	11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME <b>Frank S. Nelson</b>			14. MOTHER'S MAIDEN NAME <b>Effie E. Engelman</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____		16. SOCIAL SECURITY NO. _____	17. INFORMANT ADDRESS <b>Miss Ruth E. Nelson - 2645 Purnell Dr.</b>		

18. CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>199.1</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>552</b>	(A) <b>Carcinoma of neck</b> DUE TO (B) <b>Metastasis to spine &amp; skull</b> DUE TO <b>end with paralysis of legs.</b> (C) <b>Bladder &amp; lymphatic</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT. _____	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>9/14/50</b> , 19 <b>50</b> , to <b>April 3</b> , 19 <b>51</b> , that I last saw the deceased alive on <b>April 3</b> , 19 <b>51</b> , and that death occurred at <b>10.30 a.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>D. E. Williams</b>		23B. ADDRESS <b>1202 St Paul St</b>		23C. DATE SIGNED <b>April 4/51</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>4/5/51</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Spring Grove Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Cincinnati, Ohio</b>		25. FUNERAL DIRECTOR ADDRESS <b>2645 Purnell Dr. - Baltimore</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 5 - 1951</b>		REGISTRAR'S SIGNATURE <b>D. E. Williams</b>		25. FUNERAL DIRECTOR ADDRESS <b>2645 Purnell Dr. - Baltimore</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



## MARYLAND STATE DEPARTMENT OF HEALTH

3517

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Western Run Road</u>		STREET ADDRESS (If rural, give location) <u>Western Run Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Robert</u>	(Middle) <u>Elihu</u>	(Last) <u>Nelson</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>10</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3 May 1882</u>
9. AGE last birthday <u>68</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Blue Mount Balto. Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Blue Mount Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Sally Cuddy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>218-05-6049</u>	
17. INFORMANT AND ADDRESS <u>Emma Nelson (Wife)</u>			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on March 49, 19....., and that death occurred at 3:10 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>April 13, 1951</u>	<u>Wesley Chapel</u>	<u>Montgon, Balto. Co. Md.</u>	
DATE REC'D. BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/11/51</u>	<u>Charles J. Sullivan</u>	<u>J. Jacob Hartenstein</u>	<u>New Freedom, Penna.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

501-358

RECEIVED

APR 17 1968

BUREAU V. &

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

3518

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 7 (Rockdale)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 7 - MD (Rockdale)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3303 MAYFIELD AVE</u>		STREET ADDRESS (If rural, give location) <u>3303 MAYFIELD AVE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>EDNA</u>	(Middle) <u>GERTRUDE</u>	(Last) <u>NICKELL</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>FEB-2-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>63</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE CITY.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN MEAGHER</u>		14. MOTHER'S MAIDEN NAME <u>MARY SCHOTT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>MRS. MARY NAWROT - DAUGHTER.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) CORONARY OCCLUSION.

INTERVAL BETWEEN ONSET AND DEATH

1 DAY.

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) CORONARY ARTERIOSCLEROSIS

1 YEAR

(c) HYPERTENSIVE C-V. DISEASE

4 YEARS

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

NONE.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
OF INJURY				

22. I hereby certify that I attended the deceased from MARCH 1, 1951, to APRIL 13, 1951, that I last saw the deceased

alive on APRIL 13, 1951, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/17/51</u>	<u>Woodlawn Cem.</u>	<u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/16/51</u>	<u>A W Hedrick</u>	<u>Wm. J. Fickner &amp; Sons - Balto</u>	<u>Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3519

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore-rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore-rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>628 Overbrook Road</u>		STREET ADDRESS (If rural give location) <u>628 Overbrook Road</u>	
3. NAME OF DECEASED (Type or Print) <u>MARGARETHA</u>		(Last) <u>OCH</u>	
5. SEX <u>Female</u>		4. DATE OF DEATH <u>April 24, 1951</u>	
6. COLOR OR RACE <u>White</u>		8. DATE OF BIRTH <u>July 3, 1866</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		9. AGE last birthday <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Johann Bleisteiner</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Sorgel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		17. INFORMANT <u>Mrs. Frank Austin 628 Overbrook Road</u>	
16. SOCIAL SECURITY No. (If yes, give war or dates of service)			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Lobar Pneumonia</u>		<u>4 days</u>
Antecedent cause(s) (b) <u>General Debility</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arterial Sclerosis</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>4/15</u> , 19 <u>51</u> , to <u>4/24</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4/23</u> , 19 <u>51</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above.		
SIGNATURE (Degree or title) <u>Amelia Link Sheppard M.D.</u>		DATE SIGNED <u>2211 E. Lake Ave Balto 13 Md</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>Apr. 27, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>
		LOCATION (City, town, or county) (State) <u>Parkville, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>H.W. Hedrick</u>	24. FUNERAL DIRECTOR ADDRESS <u>Ullrich Funeral Home 2008 Orleans St.,</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3520

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Timonium Heights</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Timonium Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Padonia Rd</u>		STREET ADDRESS <u>Padonia Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) <u>E.</u> (Middle) <u>Opfel</u> (Last)		4. DATE OF DEATH <u>Apr 14</u> (Month) (Day) (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12/24/1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birth day <u>79</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward Concurron</u>		14. MOTHER'S MAIDEN NAME <u>Mary (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u></u>	
17. INFORMANT AND ADDRESS <u>Lillian Gladfelter, 5221 York Rd</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Broncho-pneumonia

## Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(b) Rheumatoid Arthritis(c) Arteriosclerosis, GeneralINTERVAL BETWEEN  
ONSET AND DEATH3 days8 weeksunk.

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY m.INJURY OCCURRED  
While at Not While  
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/9, 1951, to 4/14, 1951, that I last saw the deceasedalive on 4/9, 1951, and that death occurred at 4:40 A. a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Md.</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <b>2316 Monumental Avenue</b>	
3. NAME OF DECEASED (Type or Print) <b>HENRY J. S. OWINGS, Sr.</b>		4. DATE OF DEATH (Month) <b>April</b> (Day) <b>25</b> (Year) <b>19 51</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH <b>May 16, 1873</b>
9. AGE last birthday <b>77</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Calvert County, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Calvert County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Henry Owings</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <input checked="" type="checkbox"/>	
17. INFORMANT <b>Sarah E. Owings, wife, 2316 Monumental Ave.</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

*Generalized Severe Arteriosclerosis*

INTERVAL BETWEEN ONSET AND DEATH

*3 years*

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

*None*

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *March 15 1951*, to *April 25 1951*, that I last saw the deceasedalive on *April 24, 1951*, and that death occurred at *2:05 P.M.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*Francis J. Grumbrue M.D. 1600 Wilkens Ave. 4/26/51*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<b>Burial</b>	<b>4/28/51</b>	<b>Glen Haven Mem. Park Cem.</b>	<b>Glen Burnie, Md.</b>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<b>4/27/51</b>	<i>A.W. Hedrick</i>	<b>Schimunek Funeral Home, Inc.</b>	<b>2601-3-5 E. Madison St.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

3522

1. PLACE OF DEATH COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Md.</b> COUNTY <b>Carr oll</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Manchester</b>	
TOWN <b>Finksburg</b>		TOWN <b>Manchester</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Convalescent Home</b>		STREET ADDRESS <b>R.D. #1</b>	
3. NAME OF DECEASED (Type or Print) <b>Daniel</b> (First) <b>G.</b> (Middle) <b>Palmer</b> (Last)		4. DATE OF DEATH <b>April 23, 1951</b> (Month) (Day) (Year)	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>April 10, 1869</b>
9. AGE last birthday <b>82 yrs.</b>		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Palmer</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <b>No.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT <b>Jesse M. Tracy, Manchester, Md. #1</b>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Myocarditis - Chronic</b>	<input checked="" type="checkbox"/>
Antecedent cause(s) (b) <b>Passive congestion of base of lungs</b>	<input checked="" type="checkbox"/>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4-22-51**, 19**51**, to **4-23**, 19**51**, that I last saw the deceased alive on **4-22**, 19**51**, and that death occurred at **3:30** a.m., from the causes and on the date stated above.

SIGNATURE <b>John G. Saffell M.D.</b>	DATE SIGNED <b>4-23-51</b>
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>4/26/51</b>
NAME OF CEMETERY OR CREMATORY <b>Christ Church</b>	LOCATION (City, town, or county) (State) <b>Littlestown, Pa. Adams Co.</b>
DATE REC'D BY LOCAL REG. <b>4-23-51</b>	REGISTRAR'S SIGNATURE <b>W.A. Feiser</b>
FURNERAL DIRECTOR <b>W.A. Feiser, Hanover, Pa.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMOVED

APR 27 1961

BUREAU V. &

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7 Ridge Road</u>		STREET ADDRESS (If rural, give location) <u>7 Ridge Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Louisa</u>	(Middle) <u>U.</u>	(Last) <u>Parr</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>4</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Aug. 18, 1854--96</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>96</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>UHLBRICK</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mrs. Frank T. Parr, 7 Ridge Rd. Catonsville</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocardial Insufficiency

Antecedent cause(s)

(b) Generalized arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 5, 1948, to April 4, 1951, that I last saw the deceased alive on April 4, 1951, and that death occurred at 2:00 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>April 7/51</u>	<u>Holy Redeemer, Belair Rd. Balto. Md.</u>		
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/6/51</u>	<u>A. A. Redner</u>	<u>Harry H. Wintyer</u>	<u>4101 Edmondson Ave.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

3524

1. PLACE OF DEATH COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Owings Mills</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Reisterstown</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Reisterstown Road</b>		STREET ADDRESS (If rural give location) <b>Hanover Road</b>	
3. NAME OF DECEASED (Type or Print) <b>Ethel</b> (First) <b>Grace</b> (Middle) <b>Peregoy</b> (Last)		4. DATE OF DEATH <b>April</b> (Month) <b>29</b> (Day) <b>1951</b> (Year)	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Aug 27 1888</b>
9. AGE last birthday <b>62</b> yrs.		10. If under 1 year: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hugh Donnell McCleary</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Zeigler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT <b>Raymond M Peregoy Reisterstown Md</b>			

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) PULMONARY EDEMA

INTERVAL BETWEEN ONSET AND DEATH

2 hrs

Antecedent cause(s)

(b) HYPERTENSIVE C. V. DISEASE

5 yrs

(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

#### 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JANUARY, 1949, to APRIL 29, 1951, that I last saw the deceased

alive on APRIL 29, 1951, and that death occurred at 9:00 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Martin E. Strobel

M.D.

Reisterstown, Md.

5/1/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

May 2 1951

Reisterstown Meth Cem

Reisterstown

Md

DATE REC'D BY LOCAL REG. 5-1-51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Mary B. Zline

Wm Berryman & Sons Reisterstown Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 3 1951

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

3525

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>PIKEVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikeville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Old Court Rd.</u>		STREET ADDRESS (If rural, give location) <u>10 Old Court Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>LOUIS E. PEYTON</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Jan - 29 - 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sailmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship sailmaker</u>	9. AGE last birthday <u>76</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>B. Cristfield Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Sidney Peyton</u>		14. MOTHER'S MARDEN NAME <u>Susan Pyle</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-03-3485</u>	
17. INFORMANT <u>Mrs. Armacost, 10 old Court Rd. Pikeville</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic Myocarditis</u>	<u>6 mons.</u>
Antecedent cause(s) (b) <u>Hypertension</u>	<u>5 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Art. Sclerosis</u>	<u>8 yrs.</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN)	(COUNTY)
(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 4/9, 1951, to 4/10, 1951, that I last saw the deceased alive on 4/10, 1951, and that death occurred at 6:30 A. m., from the causes and on the date stated above.

SIGNATURE James A. Miller, M.D. ADDRESS Pikeville - 8, Md DATE SIGNED 4/11/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/12 - 51</u>	NAME OF CEMETERY OR CREMATORY <u>Gruid Ridge</u>	LOCATION (City, town, or county) <u>Pikeville 8. Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>4/12/51</u>	REGISTRAR'S SIGNATURE <u>H. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Charles H. Howell</u>	ADDRESS <u>Pikeville, Md.</u>	

594378

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3526

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Eastonsville, Md.</u> TOWN <u>Eastonsville, Md.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6305 Mt. Ridge Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Eastonsville, Md.</u> TOWN <u>Eastonsville, Md.</u> STREET ADDRESS (If rural, give location) <u>6305 Mt. Ridge Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Margaret Moraw Phillips</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>3</u> (Year) <u>1951</u>	5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 21, 1905</u>	9. AGE last birthday <u>45 yrs.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Charles Harry Moraw</u>	14. MOTHER'S MAIDEN NAME <u>Katherine Reiney</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>	16. SOCIAL SECURITY No. <u>216-01-3418</u>	17. INFORMANT AND ADDRESS <u>Roger D. Phillips</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Myocardial Infarction</u>	<u>1 week</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Lympho Sarcoma of face</u> <u>&amp; Generalized Metastasis</u>	<u>2 yrs</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>1949</u>	19b. MAJOR FINDINGS OF OPERATION <u>Lympho Sarcoma - glands</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>INJURY</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-10, 1948, to 4-3, 1951, that I last saw the deceased alive on 4-2, 1951, and that death occurred at 12:15 A m., from the causes and on the date stated above.

SIGNATURE James E. Howell (Degree or title) ADDRESS Eastonsville DATE SIGNED 4/3

23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>	DATE THEREOF <u>April 5, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG. <u>4-3-51</u>	REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	24. FUNERAL DIRECTOR <u>Easton Sons - 608 Frederick Ave.</u>	ADDRESS <u>450736 Catonsville, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
APR 5 1961  
BUREAU V. 8

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3527

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Towson Convalescent Home</u> <u>301 W. Chesapeake Avenue</u>		STREET ADDRESS (If rural give location) <u>516 W. Joppa Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Richard Thomas</u> (Middle) <u>Pilling, Sr.</u> (Last)	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>1</u> (Year) <u>19 51</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Nov. 29, 1864</u>
9. AGE last birthday <u>86</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturer- owner</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Woolens</u>		11. BIRTHPLACE (State or foreign country) <u>Kiamensi, Del.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Thomas Pilling</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Vandegrift</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT <u>Richard T. Pilling, Jr. - 516 W. Joppa Road</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

181X Immediate cause

(a) Carcinoma - Bladder

INTERVAL BETWEEN ONSET AND DEATH  
unk.

52b Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

#### II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar 1, 1951, to Mar 31, 1951, that I last saw the deceased

alive on Mar 31, 1951, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>burial</u>	<u>4 - 4 - 51</u>	<u>St. James P.E. Church</u>	<u>Stanton, Del.</u>	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4/4/51</u>	<u>A.W. [Signature]</u>	<u>John O. Mitchell &amp; Sons, Inc.</u>	<u>1900 Eutaw Place</u>

Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

3528

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Ind</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Boring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wapasco Ind</u>	
TOWN <u>Boring</u>		TOWN <u>Wapasco Ind</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Rural</u>	
3. NAME OF DECEASED (Type or Print) <u>Wiletta</u> (First) (Middle) (Last) <u>Price</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 23 1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>Aug 3 - 1872</u>
9. AGE last birthday <u>78</u> yrs. <u>10</u> months <u>10</u> days		10. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Price</u>		14. MOTHER'S MAIDEN NAME <u>Lucinia Klindinst</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Sallie Isabelle Boring</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Cerebral Hemorrhage (Hemiplegia) 4 da

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterio Sclerosis 10 yrs(c) Acute Cold 4 da

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## INTERVAL BETWEEN ONSET AND DEATH

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

## 20. AUTOPSY?

Yes ☐ No ☐ (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 19, 1951, to April 23, 1951, that I last saw the deceasedalive on April 22, 1951, and that death occurred at 5 a m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 4-23-51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 27 1951

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3529

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Balto</u> <u>Lutherville</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>		STREET ADDRESS (If rural, give location) <u>Lutherville</u>	
3. NAME OF DECEASED (First) <u>Helen</u> (Middle) <u>Russar</u> (Last) <u>Pugh</u>		4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>9</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct-5-1875</u>
9. AGE last birthday <u>75</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James S. Russar</u>		14. MOTHER'S MAIDEN NAME <u>Clara Ridgely</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Wm. D. S. Pugh (son) Towson, Md.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Bronchopneumonia  
(b) Congestive Heart failure  
(c) Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

2 days  
30 days  
unknown

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/26, 1951, to 4/9, 1951, that I last saw the deceased

live on 4/9, 1951, and that death occurred at 4:00 p.m., from the causes and on the date stated above.

SIGNATURE <u>Bennett A. Steen MD</u>	(Degree or title)	ADDRESS <u>Lutherville</u>	DATE SIGNED <u>4/9/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Apr-11-51</u>	NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>	LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
DATE REC'D BY LOCAL REG. <u>4/10/51</u>	REGISTRAR'S SIGNATURE <u>Rev. Hedrick</u>	24. FUNERAL DIRECTOR <u>Stewart &amp; Morrow Co.</u>	ADDRESS <u>108 W. North Ave.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

3530

Reg. Dist. No. 45

1. PLACE OF DEATH- COUNTY <u>Balto</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Stemmers Run</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Middle River</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pistol and Rifle Range</u>				STREET ADDRESS <u>21 Compass Rd.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH
<u>Joseph Samuel Reagan</u>					<u>4-2-1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>Sept. 2-1885</u>	9. AGE last birthday <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Handyman</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>	
13. FATHER'S NAME <u>Robert Reagan</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>		17. INFORMANT AND ADDRESS <u>M. C. Reagan 417 Susan St.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	<u>Coronary Occlusion</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>420.1</u> <u>94a</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	HOW DID INJURY OCCUR?
	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>11/25 avs JMS</u>		(Degree or title)		ADDRESS <u>11/25 avs JMS</u>		DATE SIGNED <u>4/1/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Removal</u>	<u>4/2/51</u>	<u>Presbyterian</u>		<u>Springville</u>		<u>N. Carolina</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS			
<u>April 2, 1951</u>	<u>Edith Hurley</u>	<u>John W. Connolly</u>		<u>Essex St.</u> <u>9970 VVV md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 4 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3531

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Parkville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2607 Wendover Road</u>		STREET ADDRESS (If rural, give location) <u>2607 Wendover Road.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>GEORGE</u> (Middle) <u>W.</u> (Last) <u>REECE</u>		4. DATE OF DEATH (Month) <u>Apr.</u> (Day) <u>1</u> , 1951 (Year) <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 11, 1870</u>
9. AGE last birthday <u>80</u> yrs.		10. If under 1 year: Months <u>1</u> Days <u>1</u> If under 24 hrs: Hours <u>1</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Helper, retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm work</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Solon Reece</u>		14. MOTHER'S MAIDEN NAME <u>Mary F. (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Miss Mabel Reece, 2607 Wendover Road.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Coronary Thrombosis

## Antecedent cause(s)

(b) 5 years  
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last(c) Sclerosis

## INTERVAL BETWEEN ONSET AND DEATH

1 hour5 years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 7-12, 1950, to 4-1, 1951, that I last saw the deceased alive on 4-19, 1951, and that death occurred at 1 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Remove</u>		DATE THEREOF <u>4/2/51</u>		NAME OF CEMETERY OR CREMATORY <u>Winfield</u>		LOCATION (City, town, or county) (State) <u>Winfield, W. Va.</u>	
DATE RECD BY LOCAL REG. <u>4/2/51</u>		REGISTRAR'S SIGNATURE <u>a w Hedrick</u>		24. FUNERAL DIRECTOR <u>W. R. Jones</u>		ADDRESS <u>1217 St Paul St</u>	

VJT

820105

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3532

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Vet. Adm. Hosp., Ft. Howard, Md.</b>		STREET ADDRESS (If rural, give location) <b>1351 Stockton Street</b>	
3. NAME OF DECEASED (Type & Print)	(First) <b>EDWARD</b>	(Middle) <b>S.</b>	(Last) <b>RHODES</b>
4. DATE OF DEATH	(Month) <b>April</b>	(Day) <b>16</b>	(Year) <b>1951</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>2-2-92</b>
9. AGE last birthday <b>59</b> yrs.		10. If under 1 year: Months <b>2</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Huckster</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Howard Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charlie Rhodes</b>		14. MOTHER'S MAIDEN NAME <b>Emma Harritty</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war, or dates of service) <b>WW I</b>		16. SOCIAL SECURITY No. <b>Unknown</b>	
17. INFORMANT AND ADDRESS <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		UNKNOWN
Immediate cause (a) <b>LOBAR PNEUMONIA</b>		
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **April 15 1951**, to **April 16 1951**, and that death occurred at **4:50 P. m.**, from the causes and on the date stated above.

SIGNATURE **Irving Freeman** (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Apr. 19, 1951</b>	NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	(State)
DATE REC'D BY LOCAL REG. <b>4/18/51</b>	REGISTRAR'S SIGNATURE <b>A. W. Hedrick</b>	24. FUNERAL DIRECTOR <b>Charles R. Law</b>		ADDRESS <b>802 Madison Ave., Baltimore, Maryland</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

430636

## MARYLAND STATE DEPARTMENT OF HEALTH

Dr. Bacon

2411 N. Charles Street, Baltimore

3533

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Parkville</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Parkville</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2700 Taylor Avenue</u>		STREET ADDRESS (If rural, give location) <u>2700 Taylor Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Gertrude</u>	(Middle)	(Last) <u>Rickert</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>16</u>	(Year) <u>1951</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug. 15, 1871</u>
9. AGE last birthday <u>79</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>athome</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>? Fassbender</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mr. Ignatz Rickert, 2700 Taylor Ave.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Chronic myocarditis with

INTERVAL BETWEEN ONSET AND DEATH

11 yrs +

## Antecedent cause(s)

(b)

hypertension & arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1939, to Apr - 16, 1951 that I last saw the deceasedalive on Apr. 16, 1951, and that death occurred at 8:50 A.M. from the causes and on the date stated above.

SIGNATURE

A.M. Bacon, M.D. 2810 Taylor Ave.

ADDRESS

DATE SIGNED

4/16/51

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REG'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

4/16/51A.M. BaconLeonard J. Ruck, 5305 Harford Road.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 19 1951  
BUREAU W.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

3534

1. PLACE OF DEATH - COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>	
TOWN <u>Raspeburg</u>		TOWN <u>Raspeburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4701 Fullerton Ave</u>		STREET ADDRESS (If rural, give location) <u>4701 Fullerton Ave</u>	
3. NAME OF DECEASED (First) <u>Rev. Robert</u>	(Middle) <u>L.</u>	(Last) <u>Riddle</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>22</u> (Year) <u>1957</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec. 25-1886</u>
9. AGE last birthday <u>64</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clergyman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Protestant</u>	11. BIRTHPLACE (State or foreign country) <u>Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Nathan Riddle</u>	14. MOTHER'S MAIDEN NAME <u>Ida Watson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT AND ADDRESS <u>Mrs. R.L. Riddle 4701 Fullerton Ave</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

Sudden death

## Antecedent cause(s)

(b)

Arterio-sclerotic heart disease13 yrs -

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Anginal pains on exertion

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept 1....., 1943., to Apr 3....., 1957., that I last saw the deceasedalive on Apr 3....., 1957., and that death occurred at 3:15 P.....m., from the causes and on the date stated above.SIGNATURE John A. Lutscher (Degree or title) ADDRESS 12 E. Eager St - Baltimore (2) Md - DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/25/57</u>	NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem</u>	LOCATION (City, town, or county) <u>BALTO</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>4/23/57</u>	REGISTRAR'S SIGNATURE <u>Wm. Hedrick</u>	24. FUNERAL DIRECTOR <u>Lassalun Funeral Home</u>	ADDRESS <u>7401 Balair Rd.</u>	

DM009896

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

12 E August.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3535

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>West Friendship</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>122 Hawthorne Avenue</u>		STREET ADDRESS (If rural give location) <u>McHenry Lane</u>	
3. NAME OF DECEASED (Type or Print) <u>Rosella</u> (First) <u>nni</u> (Middle) <u>Ridgely</u> (Last)		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>Dec. 31, 1870</u>
9. AGE last birthday <u>XX 80 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>	
11. BIRTHPLACE (State or foreign country) <u>Howard County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hamilton Hobbs</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Loud</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>                    </u>	
17. INFORMANT <u>Stewart O. Ridgely</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Thrombosis

Antecedent cause(s)

420.1 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

94a

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.Bronchopneumonia

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 14 Apr., 1950, to 6 Apr., 1951, that I last saw the deceasedalive on 6 April, 1951, and that death occurred at 10:30A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Charles F. Williams M.D.1331 Reisterstown Road6 April '51

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>Apr. 9, 1951</u>	<u>McKendree</u>	<u>Howard Co.</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4-25-51</u>	<u>Dr. E.E. Nichols</u>	<u>Wm. H. Haight</u>	<u>Sylva, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
APR 25 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3536 45

1. PLACE OF DEATH- COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Md.</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Middle River</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Essex</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Ivy Hall Nursing Home 19 Harrison Ave.</b>				STREET ADDRESS (If rural, give location) <b>1633 Eastern Ave.</b>	
3. NAME OF DECEASED (Type or Print) <b>Katherine</b>		(First) <b>Riley</b>		(Last)	
4. DATE OF DEATH <b>April 27 1951</b>		(Month)		(Day) (Year)	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Oct. 30, 1970</b>	9. AGE last birthday <b>80</b> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Andrew Yingling</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Gontzum</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT <b>Balto. 21, Md. Mr. Andrew E. Crum, 1633 Eastern Ave.</b>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) **Auricular Fibrillation**INTERVAL BETWEEN  
ONSET AND DEATH**2 days**

## Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(b) **Arterio-sclerotic Heart Disease****unknown**

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.**Fracture, left femur & pelvis****10 days**

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY **April 16/1951 8P** m.INJURY OCCURRED  
While at Work ☐ Not While  
At work ☒

HOW DID INJURY OCCUR?

**Fell off chair in living room**22. I hereby certify that I attended the deceased from **4/17/51**, 19....., to **4/27/51**, 19....., that I last saw the deceasedSignature on **4/26/51**, 19....., and that death occurred at **12:20P** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)**Removal**

## DATE THEREOF

**April 27, 1951**

## NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG.**4-27-51**

## REGISTRAR'S SIGNATURE

**L**

## 24. FUNERAL DIRECTOR

ADDRESS

**Rem. J. Tishner & Sons, Baltimore, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *30*

*3537*

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>3558 Poole Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARY</u>	(Middle) <u>ANNA CAPONIC</u>	(Last) <u>RUBY</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>January 15, 1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>	9. AGE last birthday <u>88</u> yrs.
13. FATHER'S NAME <u>(Unknown)</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
16. SOCIAL SECURITY No. <u>—</u>		14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records, Catonsville 28, Md.</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Lobar pneumonia, left lower lobe</u>			<u>5 days</u>
Antecedent cause(s) (b) <u>Arteriosclerotic heart disease</u>			<u>Indefinite</u>
(c) <u>Generalized arteriosclerosis</u>			<u>Indefinite</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Mar. 31, 1951, to April 4, 1951, that I last saw the deceased alive on April 4, 1951, and that death occurred at 1:15 p.m., from the causes and on the date stated above.

SIGNATURE <u>Ethel B. Hermann-Green M.D.</u>	(Degree or title)	ADDRESS <u>M.D. Spring Grove St. Hospital, Catonsville, Md.</u>	DATE SIGNED <u>4/4/51</u>
23. BURIAL CREMATION REMOVAL (Specify)	DATE <u>4/7/51</u>	NAME OF CEMETERY OR CREMATORY <u>Manchester</u>	LOCATION (City, town, or county) (State) <u>Manchester, Md.</u>
DATE RECD BY LOCAL REG. <u>4-6-51</u>	REGISTRAR'S SIGNATURE <u>L</u>	24. FUNERAL DIRECTOR <u>Paul C. Schenck</u>	ADDRESS <u>3615-11 Chestnut Ave</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3538

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2011 Dundalk Ave.</u>		STREET ADDRESS (If rural, give location) <u>2011 Dundalk Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Raymond</u>	(Middle) <u>E</u>	(Last) <u>Schario</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Aug 1 - 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth Steel</u>	9. AGE last birthday <u>56</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>John Schario</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY No. <u>216-097-452</u>	
17. INFORMANT <u>Julia M. McEoy</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Accident</u>			<u>12 hrs.</u>
Antecedent cause(s) (b) <u>Hypertension C.V.-R.D. Disease</u>			<u>4 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1948 to April 5, 1951, that I last saw the deceased alive on April 2, 1951, and that death occurred at 740 P.M., from the causes and on the date stated above.

SIGNATURE David M. Schario ADDRESS Dundalk - 22 Md DATE SIGNED 4/23/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/24/51</u>	<u>Oak Lawn</u>	<u>Eastern Ave.</u>	<u>22nd.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/24/51</u>	<u>A. W. Schario</u>	<u>John O'Connell</u>	<u>East 21</u>	

ST

685336 md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3539

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MD.</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Relayville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>16 Rusting Ave.</b>		STREET ADDRESS (If rural, give location) <b>5001 Hazel Ave.</b>	
3. NAME OF DECEASED (Type or Print) <b>J. Edmund Schueler</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>April 30/51</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 12, 1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Civil Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R.</b>	9. AGE last birthday <b>76</b> yrs.
13. FATHER'S NAME <b>John Schueler</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Rost</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <b>John E. Schueler, Jr. 5001 Hazel Ave.</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause <b>Chronic Myocarditis with Cardiac Decompensation</b>		<b>3 weeks</b>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last		<b>Undet.</b>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>1 year.</b>
19a. DATE OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR? While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>

22. I hereby certify that I attended the deceased from **November 19, 48**, to **April 30, 1951**, that I last saw the deceased alive on **April 30, 1951**, and that death occurred at **10:30 A. m.**, from the causes and on the date stated above.

SIGNATURE **Dr. Bradley Laugherty, M.D.** ADDRESS **Halcthorpe, Md. 5-1-51.** DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>May 3/51</b>	NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	LOCATION (City, town, or county) <b>Frederick</b>	(State) <b>ve. Balto. Md.</b>
DATE REC'D BY LOCAL REG. <b>5/1/51</b>	REGISTRAR'S SIGNATURE <b>A W Hedrick</b>	24. FUNERAL DIRECTOR <b>Harry H. Lutzke</b>	ADDRESS <b>2101 Edmondson Ave.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

643506

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3540

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Bare Hills Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bare Hills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bare Hills</u>	
TOWN <u>Bare Hills</u>		TOWN <u>Bare Hills</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Esther</u> (Middle) <u>Ellery</u> (Last) <u>Scott</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 8, 1867</u>
9. AGE last birthday <u>84</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Warrenton, Virginia</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matthew Christmas</u>		14. MOTHER'S MAIDEN NAME <u>Anna?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>720826</u>	
17. INFORMANT <u>Clarence S. Scott</u>		18. MEDICAL CERTIFICATION	

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

421.4 Immediate cause

(a) Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

3 weeks

92d Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic vascular disease of heart

54 years

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3:55 a.m., 1951, to 4:10 a.m., 1951, that I last saw the deceased

alive on 4:09 a.m., 1951, and that death occurred at 1:12 a.m., from the causes and on the date stated above.

SIGNATURE John E. J. Camper, M.D. (Degree or title)

ADDRESS 1634 N. Carey St., Balto., Md.

DATE SIGNED 4-11-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/12/1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. John's</u>	LOCATION (City, town, or county) <u>Ruston, Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>4/12/51</u>	REGISTRAR'S SIGNATURE <u>Alfred Hedrick</u>	24. FUNERAL DIRECTOR <u>Funeral Home</u>	ADDRESS <u>1631 Druid Hill Ave.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

3541

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Catonsville Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>1005 Ridgely Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Florence</u> (Middle) <u>E.</u> (Last) <u>Seymour</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>7</u> (Year) <u>51</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, <u>MARRIED</u> (Specify)	8. DATE OF BIRTH <u>Aug. 7, 1872</u>
9. AGE last birthday <u>78</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Howard County, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Howard County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Oden</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mr. George Seymour, 1005 Ridgely Street</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

72 hrs

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis, generalized, severe

Unknown

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4-5-51, 1951, to 4-7, 1951, that I last saw the deceased alive on 4-5, 1951, and that death occurred at 7:00 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>	DATE THEREOF <u>4/10/51</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore,</u> (State) <u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>	ADDRESS <u>1217 St. Paul Street</u>

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

3542

Reg. Dist. No. *43*

1. PLACE OF DEATH- COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>MARYLAND</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Roseburg P.O. 1965</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Lanham</i>	
TOWN <i>Fullerton</i>		TOWN <i>Balto 6.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>By 481 N. Ridge Rd.</i>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <i>Frank</i> (Middle) <i>Shondara</i> (Last) <i>Shondara</i>		4. DATE OF DEATH (Month) <i>April</i> (Day) <i>15</i> (Year) <i>1951</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept 20/1864</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, Not Retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sailor</i>	9. AGE last birthday <i>87</i> yrs. If under 1 year Months Days Hours Min. If under 24 hrs.
11. BIRTHPLACE (State or foreign country) <i>Chester, Virginia</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>unk.</i>		14. MOTHER'S MAIDEN NAME <i>unk.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <i>Mrs. Nellie Kreisel Ridge Rd.</i>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

976X Antecedent cause(s)  
 164c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) *Gunshot wound thro roof*  
 (b) *month - out L parietal bone*  
 (c) *Compound fracture frontal bone (22 calibre Remington rifle)*  
 (Suicide.)

INTERVAL BETWEEN ONSET AND DEATH *2 months*

11. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY *4 15 1951 10A*

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

*Gunshot wound thro roof/month*

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*4/17/51*

*a.w. Adcock*

*Lassahn Funeral Home 7401 Belair Rd.*

590VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write nearest town) <u>Milford</u>		CITY (If outside corporate limits, write nearest town) <u>Milford</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3619 Latham Rd</u>		STREET ADDRESS (If rural, give location) <u>3619 Latham Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Emma K. Shearer</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 4 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>82</u> yrs. If under 1 year Months Days Hours Mto.
11. BIRTHPLACE (State or foreign country) <u>Butler Co., Pa</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Valentine Hollar</u>		14. MOTHER'S MAIDEN NAME <u>Martha G. Freeman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. L. H. Mossom</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

4 hours

##### Antecedent cause(s)

(b)

Hypertensive Heart Disease

5 yrs.

##### stating the underlying cause last

(c)

Generalized Arterio-sclerosis

5 yrs.?

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

None

#### 20. AUTOPSY?

Yes ☐ No ☐

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 2, 1946, to April 22, 1951, that I last saw the deceased

alive on April 22, 1951, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Earl L. Chambers, M.D.

4108 Liberty Hts. Balto.

#### 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

Funeral Director

ADDRESS

4/23/51

Wm. Reddy

4510 Liberty Hts. Ave.

Baltimore

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3544 38

1. PLACE OF DEATH COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> TOWN <b>Rodgers Forge</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> TOWN <b>Rodgers Forge</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>6829 Blenheim Road</b>		STREET ADDRESS (If rural give location) <b>6829 Blenheim Road</b>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>Jean Brown Shearer</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>April 16, 19 51</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH <b>Dec. 8, 1859</b>
9. AGE last birthday <b>91</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>William Shearer</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Carr</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT <b>Miss Grace Shearer-6829 Blenheim Road</b>	

### 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
502.1 Immediate cause (a) <b>Pulmonary Hemorrhage</b>		<b>10 minutes</b>
106.2 Antecedent cause(s) (b) <b>Chronic Bronchitis</b>		<b>6 weeks</b>
(c) <b>Arterio-sclerosis</b>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>June 1957</b> , to <b>16 Apr 1951</b> , that I last saw the deceased alive on <b>16 Apr 1951</b> , and that death occurred at <b>11:50 P</b> m., from the causes and on the date stated above.		
SIGNATURE <b>Charles K. Reis MD</b>		DATE SIGNED <b>17 Apr 51</b>
ADDRESS <b>6701 York Road</b>		
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<b>burial</b>	<b>4/18/51</b>	<b>Loudon Park</b>
LOCATION (City, town, or county) (State)		
<b>Baltimore, Md.</b>		
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
<b>4/17/51</b>	<b>A W Hedrick</b>	<b>John O. Mitchell &amp; Sons, Inc.-1900 Eutaw Place</b>

MARGIN RESERVED FOR BINDING

PLEASE-WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pasadenale (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home of the Pines</u>		STREET ADDRESS (If rural, give location) <u>Bay Side Beach Road</u>	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>F.</u> (Last) <u>Shipley</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>5</u> (Year) <u>1951</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Sept. 16 1874</u>
9. AGE last birthday <u>76</u> yrs.		10. If under 1 year: Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager (Retired) A.A.Co. Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel County</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Adam A. Shipley</u>	
14. MOTHER'S MAIDEN NAME <u>Johanna Clark</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Dorsey Road Mrs. Ethel M. Anderson, Glen Burnie, Md.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Myocardial Decompensation

## Antecedent cause(s)

(b) Ch. Cardio-Vascular Renal Disease(c) Renal11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

TIME (Month) (Day) (Year) (Hour) OF INJURY 131a INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 13, 1951, to Apr. 5, 1951, that I last saw the deceasedalive on Apr. 4, 1951, and that death occurred at 9:30 a.m., from the causes and on the date stated above.SIGNATURE Michael K. Gallager M.D. ADDRESS Catonsville 28, Md. DATE SIGNED 4-6-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Apr. 7, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge</u>	LOCATION (City, town, or county) (State) <u>Dorsey Md.</u>
DATE REC'D BY LOCAL REG. <u>4-6-51</u>	REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	24. FUNERAL DIRECTOR <u>Thomas W. Singleton</u> <u>Glen Burnie, Md.</u>	

052888

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15







Dr. Bacon

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Balto. Co.</u> <u>Parkville</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Parkville</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore Co.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2820 Garnet Road</u>		STREET ADDRESS <u>2820 Garnet Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Lurette</u> (First) (Middle) (Last) <u>Simms</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 23 1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 9, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>77</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Fredericksburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Layton</u>		14. MOTHER'S MAIDEN NAME <u>Mary A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mr. Thomas A. Simms, 2820 Garnet Rd.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Thaemia

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic cardio-vascular-renal disease with hypertension(c) Carcinoma, left breast

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Abdominal hernia

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## INTERVAL BETWEEN ONSET AND DEATH

6 days10 yrs +3 mos40 yrs +

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 15, 1940, to April 23, 1951, that I last saw the deceasedalive on Apr. 23, 1951, and that death occurred at 9 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

G. M. Bacon, M.D.2810 Taylor Ave.4/24/51

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial4-51Parkwood CemeteryBaltimore, Maryland

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/24/51G. M. BaconLeonard J. Ruck, 5305 Harford Road

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
APR 26 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

3547

1. PLACE OF DEATH COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Carrollville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>315 Inglewood Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u> STREET ADDRESS (If rural, give location) <u>Corbett Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>Thomas</u> (Middle) <u>Shipper</u> (Last)		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>19</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>15-1853</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	9. AGE last birthday <u>79</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John Shipper</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Lawrence P. Shipper</u>	
17. INFORMANT AND ADDRESS <u>Monkton Md.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>(a) Myocardial degeneration &amp; failure</u>		<u>Unknown</u>	
Antecedent cause(s) <u>(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		<u>(c) Arteriosclerosis, generalized, severe</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-19</u> , 19 <u>51</u> , to <u>4-25</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4-19</u> , 19 <u>51</u> , and that death occurred at <u>7:00 A.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Stephen Lee Hames MD</u>		ADDRESS <u>Carrollville 78, Md</u>	
DATE SIGNED <u>4-25-51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4-28-51</u>	
NAME OF CEMETERY OR CREMATORY <u>Carrollville</u>		LOCATION (City, town, or county) <u>Carrollville, Balto. Md.</u>	
DATE REC'D BY LOCAL REG. <u>4/25/51</u>		REGISTRAR'S SIGNATURE <u>V.E. Barry</u>	
24. FUNERAL DIRECTOR <u>Lawrence P. Shipper</u>		ADDRESS <u>Monkton Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1820105

RECEIVED  
APR 26 1961  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3548

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Balto co</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Whitmarsh</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>444 Hail. N. H</u>		STREET ADDRESS (If rural, give location) <u>Phila Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>AMONDA</u>	(First) <u>EFFIE</u>	(Last) <u>SMITH</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>8</u> (Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept 23 1872</u>
9. AGE last birthday <u>78</u> yrs.	10. KIND OF BUSINESS OR INDUSTRY <u>Packer</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Co md</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Wm Knight</u>		14. MOTHER'S MAIDEN NAME <u>Ada Morris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT <u>Mrs. Henry Fawcett Phila. Rd. Whitmarsh.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>		<u>Sudden</u>
Antecedent cause(s) (b) <u>Rheumatic Melitus</u>		<u>10 yrs</u>
(c) <u>Senile Secondary anaemia</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>April 7, 1951</u> , to <u>April 8, 1951</u> , that I last saw the deceased alive on <u>April 8, 1951</u> , and that death occurred at <u>6 P</u> m., from the causes and on the date stated above.		
SIGNATURE <u>William Gardner M.D.</u> (Degree or title)		ADDRESS <u>Balto 6 md</u> DATE SIGNED <u>4-8-51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>4/11/51</u>	NAME OF CEMETERY OR CREMATORY <u>Camp Chapel. Cem.</u> LOCATION (City, town, or county) (State) <u>Balto co md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>L</u>	24. FUNERAL DIRECTOR <u>Larsen Funeral Home 7401 Balin Rd Balto co md.</u> ADDRESS

APR 9 1951

640609

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition  
in 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

3549

FILM No. G-152 APR 18 1951

Reg. Dist. No. 39

1. PLACE OF DEATH COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Jacksonville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Phoenix</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Paper Mill Road-Hayes Farm</b>		STREET ADDRESS (If rural, give location) <b>Paper Mill Rd.</b>	
3. NAME OF DECEASED (Type or Print) <b>ELIJAH</b> (First) <b>JAMES</b> (Middle) <b>SMITH</b> (Last)		4. DATE OF DEATH <b>April</b> (Month) <b>8</b> (Day) <b>1951</b> (Year)	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>7/10/1890</b>
9. AGE last birthday <b>60</b> yrs.		10. CITIZEN OF WHAT COUNTRY? <b>Baltimore Co. Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Baltimore Co. Md.</b>	
13. FATHER'S NAME <b>Charles W. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Laura O. Carmady</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Clara Laudeman 5904 Bellona Ave.</b>	

## 18. MEDICAL CERTIFICATION

### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a)

**Coronary artery sclerosis**

Antecedent cause(s) (b)

**O. C. acute alcoholism**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

**(4/18/51 akc)**

### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) **Burial**

DATE THEREOF **4/11/51**

NAME OF CEMETERY OR CREMATORY **Fairview**

LOCATION (City, town, or county) **Jannettsville, Maryland**

(State)

DATE REC'D BY LOCAL REG. **APR 9 1951**

REGISTRAR'S SIGNATURE **L**

24. FUNERAL DIRECTOR **1219 9th St**

ADDRESS

674307



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3550 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>23 East Chesapeake Ave.</u>		STREET ADDRESS (If rural, give location) <u>23 East Chesapeake Ave.</u>	
3. NAME OF DECEASED (First) <u>Milford</u> (Middle) <u>Smith</u> (Last) <u>Smith</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 7, 1888</u>
9. AGE last birthday <u>63</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bus driver</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Smith</u>		14. MOTHER'S MAIDEN NAME <u>Dora Carroll</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>215-01-3992</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Milford Smith, Towson, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Cerebral Thrombosis</u>	<u>1 day</u>
Antecedent cause(s)	(b) <u>Arteriosclerosis - hypertension</u>	<u>5 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) <u>Arteriosclerotic heart disease</u>		<u>1 1/2 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
OF INJURY		

22. I hereby certify that I attended the deceased from May, 191945 to April 10, 1951, that I last saw the deceased alive on April 10, 1951, and that death occurred at 2:10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Elizabeth B. Sherrill, M.D. ADDRESS Cockeysville, Md. DATE SIGNED April 10, 1951

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 13, 1951</u>	<u>St. John's Catholic Cem.</u>	<u>Towson, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4/10/51</u>	<u>H. W. Haduch</u>	<u>John Burns &amp; Sons</u>	<u>Towson, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3551

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH: COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Baltimore</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8709. Harford Rd.</u>		STREET ADDRESS (If rural, give location) <u>8709. Harford Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Elsie</u>	(Middle) <u>L.</u>	(Last) <u>Sonn</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>10</u>	(Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 17-1894</u>
9. AGE last birthday <u>56 yrs.</u>	If under 1 year Months <u></u> Days <u></u>	If under 24 hrs. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>	
11. BIRTHPLACE (State or foreign country) <u>ST. Mary's Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Hayden Graves</u>		14. MOTHER'S MAIDEN NAME <u>M. Edna Woods</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mr. F. W. Sonn Jr. 8709. Harford Rd.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) metastatic carcinoma

153X Antecedent cause(s) (b) carcinoma of sigmoid colon

46e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 1 yr

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-22, 1950, to 4-10, 1951, that I last saw the deceased alive on 4-10, 1951, and that death occurred at 9:45 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Harold A. Pratt, M.D.8100 Harford Road4-12-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/14/51</u>	NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>	LOCATION (City, town, or county) <u>Baltimore</u>	(State) <u>md</u>
DATE REC'D BY LOCAL REG. <u>4-12-51</u>	REGISTRAR'S SIGNATURE <u>L</u>	24. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>	ADDRESS <u>7401 Balair Rd.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Sh. Pratt  
8100 Hayford Rd

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3552

1. PLACE OF DEATH- COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edgewood</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rev. A. Opitz Nursing Home, Edmondson Ave. &amp; Nunmery Lane</u>		STREET ADDRESS <u>Edmondson Ave. &amp; Nunmery Lane</u>	
3. NAME OF DECEASED (First) <u>Elizabeth</u> (Middle) <u>Spraker</u> (Last) <u>Spraker</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Sept. 19, 1870</u>
9. AGE last birthday <u>81</u> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>No occupation</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Punte</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Punte</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>No</u>	
17. INFORMANT AND ADDRESS <u>Harry W. Spraker (Son) Edgewood, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
Immediate cause (a)	<u>Myocarditis - Subacute</u>		
Antecedent cause(s) (b)	<u>Senility</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE <u>Mo</u> HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/11, 1951, to 4/6, 1951, that I last saw the deceased alive on 4/5, 1951, and that death occurred at 9:00 p.m., from the causes and on the date stated above.

SIGNATURE J. K. Brown (Degree or title) M.D. ADDRESS Catonsville, Md. DATE SIGNED 4/6/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>April, 9, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>4/6/51</u>	REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	24. FUNERAL DIRECTOR <u>Howard K. McComas</u>	ADDRESS <u>Abingdon, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

*Victor L. Lamy*

Vol. 11, 8, 1921 Baltimore Cemetery

Howard K. McCoomes' Springfield, Mo.  
Baltimore, Md.



NO NO

Various Prizes

No Occupation

none

Female

White

Age 28

Harold A. Spink (son) Springfield, Mo.  
Mary Elizabeth Spink  
Baltimore, Maryland

Sept. 13, 1920

BT

U.S.A.

Elizabeth

Spink

Vol. 11 & 12

Rev. A. C. Bitts Nursing Home  
Care

Edmondson Ave & Murray Ave

Baltimore County

Harford

K

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3553

## CERTIFICATE OF DEATH

Reg. Dist. No. X3

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fitch Lane</u>		STREET ADDRESS (If rural, give location) <u>Fitch Lane, Fullerton</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Mary</u> (Middle) <u>Elizebeth</u> (Last) <u>Steen</u>		4. DATE OF DEATH (Month) <u>Apr.</u> (Day) <u>9</u> (Year) <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 15, 71</u>
9. AGE last birthday <u>79</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Eckstorn</u>		14. MOTHER'S MAIDEN NAME <u>Brauer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. Sigurd Steen 135 S. Potomac</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Myocardial InfarctInterval BETWEEN ONSET AND DEATH April 2 - April 9, 51

## Antecedent cause(s)

(b)

cardio-vascular-renal disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

due to arterio-sclerosis

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from April 2, 1951, to April 9, 1951, that I last saw the deceasedalive on April 9, 1951, and that death occurred at 5:25 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Louis B. Brummeier M.D. - 722 No. Kenwood Ave APR 10 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Apr. 12, 51</u>	<u>Immanuel Cemetery</u>	<u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>APR 11 1951</u>	<u>[Signature]</u>	<u>Paul A. Heemann</u>	<u>6067 Harford R.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3554 43

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Fullerton</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fitch Lane</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u> TOWN STREET ADDRESS (If rural, give location) <u>Fitch Lane</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Siguard</u>	(Middle) <u>M.</u>	(Last) <u>Steen</u>
6. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Dec. 29, 1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Clerk - Fitch &amp; Co. Limited</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Bergen Norway</u>
13. FATHER'S NAME <u>Gerhard Steen</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-09-6163</u>	
		17. INFORMANT AND ADDRESS <u>Mr. Gerhard Steen 6010 Glenoak Ave</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Broncho-pneumonia</u>	INTERVAL BETWEEN ONSET AND DEATH <u>4/13/51</u>
Antecedent cause(s) (b) <u>Carcinoma of Rectum about 46 L</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	<u>6 months</u>
(c) <u>this had infiltrated bladder causing urinary symptoms</u>	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>General Wascen - anemia</u>	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from April 13, 1951, to April 17, 1951, that I last saw the deceased alive on April 16, 1951, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

SIGNATURE <u>Louis F. Krumrein M.D.</u>	(Degree or title)	ADDRESS <u>222 W. Kenwood Ave</u>	DATE SIGNED <u>4/17/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/18/51</u>	NAME OF CEMETERY OR CREMATORY <u>Immanuel Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
DATE REC'D BY LOCAL REG. <u>4/18/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Paul A. Heemann</u>	ADDRESS <u>6067 Harford Rd.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

390VVV

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3555

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto.22.Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Turner Station Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>546 New Pittsburg Ave</u>		STREET ADDRESS <u>546 New Pittsburg Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>David</u> (Middle) <u>H.</u> (Last) <u>Stevenson</u>	4. DATE OF DEATH (Month) <u>4</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2/22/1861</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	9. AGE last birthday <u>90</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unkown</u>		14. MOTHER'S MAIDEN NAME <u>Unkown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT AND ADDRESS <u>Marie Watkins 245 New Pittsburg Ave</u>			

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Sepsis  
 Antecedent cause(s) (b) Heart Disease, Coronary  
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3-1, 1951, to 4-8, 1951, that I last saw the deceased

alive on 4-8, 1951, and that death occurred at 4:45 p.m., from the causes and on the date stated above.

SIGNATURE Edith L. Johnson M.D. ADDRESS 473 New Pittsburg Ave DATE SIGNED 4/8/51

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>4/4/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem.</u>	LOCATION (City, town, or county) (State) <u>Brooklyn Md.</u>
--	------------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS Elney C. Wilson 1000 Brantly Ave

MADE RECD BY LOCAL REG. 11/1/51 W. H. Hedrick

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL, and OR give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Daughters of the Evangelist</u>		STREET ADDRESS (If rural, give location) <u>1721 Laurens St</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Jennie</u> (Middle) <u>Sullivan</u> (Last)	4. DATE OF DEATH	(Month) <u>Apr</u> (Day) <u>12</u> (Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Feb 25 1866</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>85</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Schneider</u>		14. MOTHER'S MAIDEN NAME <u>Sullivan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Dorothy Hamle 6600 Old Port Rd</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Acute Cardiac failure

Antecedent cause(s)

(b)

Coronary vascular disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Senility

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 5 1951 to April 12 1951, that I last saw the deceased alive on April 5 1951, and that death occurred at 3-30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/13/51

V.E. Harvey

5305 Harford Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A17  
2470 West Blvd  
4-10-51  
Be at home  
1010 Fed Ave

RECEIVED

APR 16 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

3557

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Balto.</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Boring</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Boring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
		<u>EDWARD</u>	<u>B.</u>	<u>SWINNMER</u>	<u>April</u> <u>6</u> <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>July 10, 1885</u>	9. AGE last birthday <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Bags</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>	
13. FATHER'S NAME <u>John Swinnmer</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Swinnmer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <u>Mrs. E. Elizabeth Swinnmer - Boring, Md.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

332X Immediate cause (a) Cerebral embolism

83.6 Antecedent cause(s) (b) Peripheral vascular disease, heart dilatation, generalized arteriosclerosis

(c)

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
	--	INJURY	--	--	--
TIME (Month) (Day) (Year) (Hour) OF INJURY	--	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 6, 1948 to April 4, 1951, that I last saw the deceased alive on April 4, 1951, and that death occurred at 1 3 pm., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/9/51</u>	<u>Parkwood Cem.</u>	<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4-9-51</u>	<u>[Signature]</u>	<u>Wm J. Tidman &amp; Sons</u>	<u>[Address]</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A151

Q280-458

## MARYLAND STATE DEPARTMENT OF HEALTH

3558

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 35  
39

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ROVERA - PARKTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Parkton (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Road</u>		STREET ADDRESS <u>York Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Robert Elmer Thompson</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>5</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>5-15-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Owner)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	9. AGE last birthday <u>60</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Augusta Co. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Robert Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Annia Hutchins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-31-10-1117</u>	
17. INFORMANT <u>Mr. May Thompson, Parkton, Md.</u>			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

973.3 Immediate cause

(a) Carbon Monoxide Poisoning

1630

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## INTERVAL BETWEEN ONSET AND DEATH

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

## (CITY OR TOWN)

## (COUNTY)

## 20. AUTOPSY?

Yes ☐ No ☒

## TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

## HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

## SIGNATURE

(Degree or title)

## ADDRESS

## DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY

## MATORY

## LOCATION (City, town, or county)

## (State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

4/6/51

W. J. Whitcomb

Dorothy M. Brooks, Parkton, Md.

100105

Mrs. Howard S. Markline

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

APR 20 1961

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3559

## 1. PLACE OF DEATH:

County BaltimoreCity or town Springfield Md

(If country or town limit write RURAL and give nearest town)

How long in above place of death? LifeHospital, institution, or street address where death occurred: \_\_\_\_\_How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Springfield Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1068 G St

(If rural, give LOCATION)

2(a) If veteran, name war no

## 3. (a) FULL NAME

Frederick Thomas Tillman

## 3. (b) Social Security Number

217-07-11754. Sex m5. Color or race col6. (a) Single, married, widowed, or divorced yes6. (b) Name of husband or wife Agnes Hilda Tillman7. Birth date of deceased (mo., day, yr.) July 20th 19176. (c) If alive, give age 28 years8. AGE: Years 33 Months 8 Days 28 (less than one day)

hrs. min.

9. Birthplace md.

(Town, county, and state)

10. Usual occupation laborer11. Industry or business Steel mills12. Name Eli Tillman13. Birthplace n.c.14. Maiden name Callie Loman15. Birthplace n.c.16. Informant Mrs Agnes TillmanAddress 1008 G. St.17. Burial Date thereof April 18, 1951

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Calvary AveLocation Anne Arundel Co., Md18. Funeral director Masterman H. HensleyAddress 578 W. Biddle St.19. 4/6 19 51 aa Frederick

(Date by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 15th 1951 at 1 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 28th 1951 to April 15th 1951and that I last saw him live on April 15th 19 51Immediate cause of death Rheumatic heartChronic valvular disease -Due to 4148Due to 920Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_23. SIGNATURE F. N. Thomas MD.Address 107 N. Main StContact 22 MD 4/15/51

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3560  
Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Burner's Station</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Burner's Station</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>105 Woodland Ave Dundalk Md</u>	
3. NAME OF DECEASED (First) <u>Frank</u> (Middle) <u>TIZER</u> (Last)		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>1st</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, <u>MARRIED</u> , DIVORCED (Specify)	8. DATE OF BIRTH <u>October 15-1879</u> 71 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labr</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mills</u>	9. AGE last birthday <u>71</u> yrs <u>6</u> mos
13. FATHER'S NAME <u>Joseph Name</u>		14. MOTHER'S MAIDEN NAME <u>Anna Patkai</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If year, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-07-4678</u>	
		17. INFORMANT <u>Steve Tizer</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 yrs.</u>
Immediate cause (a) <u>Lobar Pneumonia</u>			
Antecedent cause(s) (b) <u>Multiple Sclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from March 1st 1951, to April 1st 1951, that I last saw the deceased alive on April 1st 1951, and that death occurred at 6 A m., from the causes and on the date stated above.

SIGNATURE <u>Joseph H. Thomas M.D.</u>	DATE SIGNED <u>4/1/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>April 9/51</u>
NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
DATE REC'D BY LOCAL REG. <u>4/2/51</u>	24. FUNERAL DIRECTOR <u>William F. Home</u> ADDRESS <u>2122 Dundalk</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **3561**  
**33**

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Woodensburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>rural - Woodensburg, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>XX</u>		STREET ADDRESS (If rural, give location) <u>Reisterstown Md. R.F.D.</u>	
3. NAME OF DECEASED (Type or Print) <u>Kate</u> (First) <u>Isabelle</u> (Middle) <u>Tracy</u> (Last)		4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Feb 29 - 1860</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>91</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Unknown - USA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William Mabbott</u>		14. MOTHER'S MAIDEN NAME <u>Margaret McCallum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Leona C Fowble</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>			<u>4 da.</u>
Antecedent cause(s) (b) <u>Myocarditis</u>			<u>5 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arterio-sclerosis</u>			<u>20 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 11, 1951, to Apr 15, 1951, that I last saw the deceased alive on April 11, 1951, and that death occurred at 2:30 p.m. from the causes and on the date stated above.

SIGNATURE <u>Paul E Fowble Md.</u>		ADDRESS <u>Reisterstown Md.</u>		DATE SIGNED <u>April 15-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>April 16, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Finksburg Cemetery</u>	LOCATION (City, town, or county) <u>Finksburg Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>4-14-51</u>	REGISTRAR'S SIGNATURE <u>May Eline</u>	24. FUNERAL DIRECTOR <u>Wm Bernzman's Sons, Reisterstown, Md</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A131

RECEIVED

1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

3562

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) _____	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Willow Spring Road near Woodley Road</u>		STREET ADDRESS (If rural, give location) _____	
3. NAME OF DECEASED (Type or Print) <u>UNKNOWN</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, <del>MARRIED</del> , <del>WIDOWED</del> , <del>DIVORCED</del> , (Specify)	8. DATE OF BIRTH <u>NEW BORN</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>yr.</u> If under 1 year Months _____ If under 24 hrs. Days _____ Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
983 Immediate cause (a) <u>Abandonment of newborn child</u>			
195c Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input checked="" type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Stanley H. Quilader</u> (Degree or title)		ADDRESS <u>700 Fleet St. Balto.</u> DATE SIGNED <u>April 22, 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>4/24/51</u>	NAME OF CEMETERY OR CREMATORY <u>Cremated</u>	LOCATION (City, town, or county) (State) <u>City Morgue</u>
DATE REC'D BY LOCAL REG. <u>4-24-51</u>	REGISTRAR'S SIGNATURE <u>from City Health Dept.</u>	24. FUNERAL DIRECTOR ADDRESS	

90/421199/99V

Cremated at Morgue 4/24/51 at 11:00 am

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3563

Reg. Dist. No. 25

1. PLACE OF DEATH COUNTY <u>Baltimore</u> <u>20</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Balt.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Balt. Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Joy Hall - Balt. 20</u>		STREET ADDRESS (If rural, give location) <u>9012 - Ridge Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Lillian</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Nov 12 - 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Seamstress</u>		10h. KIND OF BUSINESS OR INDUSTRY <u>Own</u>	9. AGE last birthday <u>78</u> yrs.
13. FATHER'S NAME <u>James W. Van Sant</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>MARY E. Morris</u>	
16. SOCIAL SECURITY No.		17. INFORMANT <u>Mary G. (NIECE) Gosnell</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebral Thrombosis</u>						
Antecedent cause(s) (b) <u>ASHD, cerebral arteriosclerosis</u>						
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)						
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION		19h. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Sept 49</u> , 19 <u>49</u> , to <u>4/18</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4/13</u> , 19 <u>51</u> , and that death occurred at <u>12:30</u> a.m., from the causes and on the date stated above.						
SIGNATURE <u>Dorothy J. Jansen</u>		(Degree or title) <u>MD.</u>		ADDRESS <u>30 Chancellors Rd</u>		DATE SIGNED <u>4/14/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE <u>4/17/51</u>		NAME OF CEMETERY OR CREMATORY <u>Balto.</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
DATE REC'D BY LOCAL REG. <u>4/16/51</u>		REGISTRAR'S SIGNATURE <u>A. W. Padgett</u>		24. FUNERAL DIRECTOR <u>Wm. G. G. Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633111

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

3564

1. PLACE OF DEATH COUNTY <b>BALTO</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <b>OVERLEA</b> TOWN <b>OVERLEA</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>7729 BELAIR RD</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>BALTO</b> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <b>OVERLEA</b> TOWN <b>OVERLEA</b> STREET ADDRESS (If rural give location) <b>7729 BELAIR RD</b>	
3. NAME OF DECEASED (Type or Print) <b>CHARLES J. VECCHIONE</b> (First) (Middle) (Last)		4. DATE OF DEATH <b>4-9-1951</b> (Month) (Day) (Year)	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>NOV 6 1931</b> (Month) (Day) (Year)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STOCK CLERK AMERICAN STORES</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <b>19</b> yrs. If under 1 year: Months <b>3</b> Days <b>3</b> Hours <b>19</b> Mins.
11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>FREDERICK VECCHIONE</b>		14. MOTHER'S MAIDEN NAME <b>CLARA GROSS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>219-28-0949</b>	
17. INFORMANT <b>MRS. C. MICHAEL</b>		17. ADDRESS <b>7729 BELAIR RD</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <b>Cardiac Decompensation with Acute Dilatation</b>			
Antecedent cause(s) (b) <b>Chronic Endocarditis with Mitral Stenosis, Pulmonary Hypertension</b>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Rheumatic Carditis</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Commissurotomy</b>			
19a. DATE OF OPERATION <b>Mar 12, 51</b>	19b. MAJOR FINDINGS OF OPERATION <b>Mitral Stenosis</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Jan 7**, 19**51**, to **Apr 9**, 19**51**, that I last saw the deceased alive on **Apr 7**, 19**51**, and that death occurred at **2 P** m., from the causes and on the date stated above.

SIGNATURE **E. H. Donnell M.D.** ADDRESS **78 Mt Royal Ave Baltimore** DATE SIGNED **Apr 10, 1951**

23. BURIAL, CREMATION, REPOVAL (Specify) **BURIAL** DATE THEREOF **7/13/51** NAME OF CEMETERY OR CREMATORY **BALTO** LOCATION (City, town, or county) (State) **E. NORTH AVE**

DATE REC'D BY LOCAL REG. **4/10/51** REGISTRAR'S SIGNATURE **AW. Hedrick** 24. FUNERAL DIRECTOR **JOHN A MILLER** ADDRESS **2334 JEFFERSON ST**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

390636

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

3565

1. PLACE OF DEATH COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Md.</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Parkville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Baltimore (Parkville)</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>7806 Clarkworth Place</b>		STREET ADDRESS (If rural, give location) <b>7806 Clarkworth Place</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>Ethel</b>	(Middle) <b>Louise</b>	(Last) <b>Wagner</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	4. DATE OF DEATH (Month) <b>April</b> (Day) <b>15</b> (Year) <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	8. DATE OF BIRTH <b>4/18/1904</b>	9. AGE last birthday <b>46</b> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Philadelphia Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles F. Ihne</b>		14. MOTHER'S MAIDEN NAME <b>Anna Nuller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT AND ADDRESS <b>August C. Wagner 7806 Clarkworth</b>		Place	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) **coronary thrombosis** 1 hr

93d Antecedent cause(s) (b) **hypertensive cardiac vascular disease** 6 mo

(c) **disease**

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) <b>—</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>—</b>	(CITY OR TOWN) <b>—</b>	(COUNTY) <b>—</b>	(STATE) <b>—</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>—</b>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <b>—</b>		

22. I hereby certify that I attended the deceased from **Nov.**, 19**50**, to **April 15**, 19**51**, that I last saw the deceased alive on **4-15**, 19**51**, and that death occurred at **3:45 A.m.**, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

**J. D. Moore, M.D.** **3105 Belair Rd #13** **4-16-51**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Apr. 18, 51</b>	NAME OF CEMETERY OR CREMATORY <b>Immanuel</b>	LOCATION (City, town, or county) <b>Baltimore Md</b>	(State) <b>—</b>
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DATE REC'D BY LOCAL REG. <b>4/8/51</b>	REGISTRAR'S SIGNATURE <b>A. W. Adcock</b>	24. FUNERAL DIRECTOR <b>Paul A. Heemann</b>	ADDRESS <b>6067 Harford Rd.</b>
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 1A1

1957  
1904  
—  
49

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

3566

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Franklinton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Franklinton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5331 Dogwood Rd.,</u>		STREET ADDRESS (If rural, give location) <u>5331 Dogwood Rd.</u>	
3. NAME OF DECEASED (First) <u>Henry</u> (Middle) <u>Walbroel</u> (Last) <u>Walbroel</u>		4. DATE OF DEATH (Month) <u>Apr.</u> (Day) <u>14,</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan. 17, 1866</u>
9. AGE last birthday <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>214-26-7061</u>	
17. INFORMANT AND ADDRESS <u>Mrs. E.M. Reitz 5331 Dogwood Rd.,</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☐

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-15, 1950, to 4-14, 1951, that I last saw the deceased

alive on 4-14, 1951, and that death occurred at 7 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

#### 23. BURIAL CREMATION REMOVAL (Specify)

#### DATE THEREOF

#### NAME OF CEMETERY OR CREMATORY

#### LOCATION (City, town, or county)

(State)

Burial

4-17-1951

Lorraine Park

Woodlawn,

Md.

#### DATE REC'D BY LOCAL REG.

#### REGISTRAR'S SIGNATURE

#### 24. FUNERAL DIRECTOR

#### ADDRESS

4/16/51

a.w. [Signature]

G. Howard Strong 3207 W. North Ave.,

820105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3567

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Halethorpe</u>		LENGTH OF STAY (in this place) <u>8 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Halethorpe</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1821 Arbutus ave</u>				STREET ADDRESS (If rural, give location) <u>1821 Arbutus ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Lallie</u>		(First) <u>Lessop</u>		(Last) <u>Wheeler</u>	
4. DATE OF DEATH		(Month) <u>Apr</u>		(Day) <u>23</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	
8. DATE OF BIRTH		9. AGE last birthday <u>86</u> yrs.		10. If under 1 year Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Howard Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James Owens Lessop</u>		14. MOTHER'S MAIDEN NAME <u>Laura Suffeth Owens</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mrs Robert Peddicord 1921 Arbutus ave Halethorpe 27a</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Cancer of StomachINTERVAL BETWEEN  
ONSET AND DEATH9 yrs

## Antecedent cause(s)

(b)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause lastGeneral Carcinomatosis6 mo

(c)

Myocardial infarction1 mo

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Not While  
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1940, to Apr 23, 1951, that I last saw the deceased  
alive on Apr 23, 1951, and that death occurred at 2 53 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REG'D BY LOCAL  
REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

BURIAL APRIL 24, 1951 THE OLD QUAKER CEM. Rockyville, Balto., Md.  
4/24/51 W. H. Hedrick James T. Ambrose Jr. 13280 Sulphur Spring Rd.  
781-226

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A157



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *3568*

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>249 W. Hoffman St.</u>	
3. NAME OF DECEASED (First) <u>JOHN</u> (Middle) <u>E.</u> (Last) <u>WHITAKER</u>		4. DATE OF DEATH (Month) <u>Apr.</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>5-14-90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>bank</u>	9. AGE last birthday <u>60</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alex Whitaker</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Whitaker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW-1</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Clinical Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Addison's Disease

INTERVAL BETWEEN ONSET AND DEATH

unknown

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Tuberculosis of adrenal glandsunknown

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-28, 1951, to 4-14, 1951, that I saw the deceasedSignature Gene D. Trettin

(Degree or title)

ADDRESS

DATE SIGNED

GENE D. TRETIN, M.D. VAH FT. HOWARD, MD.

4-14-51

## 23. BURIAL, CREMATION OR REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

4/16/51A. W. HedmanVergie Ringgold 1463 N. Carey St. Balto. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

970000

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3569

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Vet. Adm. Hosp., Ft. Howard, Md.</b>		STREET ADDRESS (If rural, give location) <b>1566 Ridgely Street</b>	
3. NAME OF DECEASED (First) <b>HERMAN</b> (Middle) <b>M.</b> (Last) <b>WIEGAND</b>		4. DATE OF DEATH (Month) <b>April</b> (Day) <b>13</b> (Year) <b>51</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>12-31-99</b>
9. AGE last birthday <b>51</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Wiegand</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Winn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>218-03-0471</b>	
17. INFORMANT AND ADDRESS <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **BILATERAL PULMONARY TUBERCULOSIS**

INTERVAL BETWEEN ONSET AND DEATH  
**UNKNOWN**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) <b>SUICIDE</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>HOMICIDE</b>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **April 7, 1951**, to **April 13, 1951**, and that death occurred at **3:25 A.M.**, from the causes and on the date stated above.

SIGNATURE **Irving Freeman**

(Degree or title)

ADDRESS

DATE SIGNED

**IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 4-13-51**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Apr 16-1951</b>	NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	(State)
---	---------------------------------	---	---	---------

DATE REC'D BY LOCAL REG. **April 14, 1951** REGISTRAR'S SIGNATURE **R.W.**

24. FUNERAL DIRECTOR, **John W. Teufel** ADDRESS **5311 Edmondson Avenue**

**Baltimore, Maryland**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3570

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>md</b> COUNTY <b>BALTO.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK, 22</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>101 VENTNOR TERRACE</b>		STREET ADDRESS (If rural, give location) <b>101 VENTNOR TERRACE</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>HALLOCK</b> (Middle) <b>BROMLEY</b> (Last) <b>WILLIAMS</b>	4. DATE OF DEATH (Month) <b>APR.</b> (Day) <b>3</b> (Year) <b>1951</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>7/27/1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERINTENDANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PUBLIC BLDGS.</b>	9. AGE last birthday <b>75</b> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>BALTO. md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>H. B. WILLIAMS, SR.</b>		14. MOTHER'S MAIDEN NAME <b>MARY E. KING</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY No. <b>215-05-0534</b>	
17. INFORMANT AND ADDRESS <b>FRANK J. McMAHON - STEP-SON</b>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a)

**Chronic Myocarditis**

##### INTERVAL BETWEEN ONSET AND DEATH

**10 yrs**

##### Antecedent cause(s)

(b)

**422.2 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last**

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

#### 21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Febr 1**, 19**49**, to **April 3**, 19**51**, that I last saw the deceased

alive on **April 2**, 19**51**, and that death occurred at **10 20** a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

#### 23. BURIAL CREMATION REMOVAL (Specify)

#### DATE THEREOF

#### NAME OF CEMETERY OR CREMATORY

#### LOCATION (City, town, or county)

#### (State)

#### DATE REC'D BY LOCAL REG.

#### REGISTRAR'S SIGNATURE

#### 24. FUNERAL DIRECTOR

#### ADDRESS

**April 4-1951**

**William M. Kelly Jr.**

**Walter Burke Bradley, Dundalk, Md.**

290 936

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition MARYLAND STATE DEPARTMENT OF HEALTH  
of 21 shown on:

# CERTIFICATE OF DEATH

3571

FILE No. G 132 APR 13 1951 FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Freeland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Freeland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Paul</u> (Middle) <u>E.</u> (Last) <u>Workinger</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov. 20, 1891</u>
9. AGE last birthday <u>59</u> yrs.		10. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Workinger</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Schenkel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>U.S. Army</u>		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Catherine M. Workinger, Freeland, Maryland</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Immediate cause</u> <u>Carbon Monoxide poisoning</u>			
(b) <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office, field, etc.) <u>near his home</u> (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Apr 1, 1951</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR? <u>Motor vehicle exhaust (4/11/51 aka)</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>A. M. France</u>		ADDRESS <u>M.D. Parkerson Ltd</u>	
DATE SIGNED <u>4/2/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/4/51</u>	
NAME OF CEMETERY OR CREMATORY <u>U. S. National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>4/3/51</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Cook, Inc.</u>		ADDRESS <u>1217 St. Paul Street</u>	

JTV

100105



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3572 38

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balts.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Boyce ave</u>		STREET ADDRESS (If rural, give location) <u>Boyce ave</u>	
3. NAME OF DECEASED (First) <u>Sarah</u> (Middle) <u>Bruen</u> (Last) <u>Wright</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>23</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>Sept 1, 1854</u>
9. AGE last birthday <u>96</u> yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Dayton Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Luther Barnett Bruen</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Forrer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Alice Wright</u>		Same	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Branches Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

2 Weeks

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Arterio Sclerosis

12 year

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
HOMICIDE	INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July 37, 1951, to 23 am, 1951, that I last saw the deceased

alive on 23 Apr, 1951, and that death occurred at 23 am, from the causes and on the date stated above.

SIGNATURE Charles H. Keis (Degree or title) M.D. ADDRESS 6701 York Rd Balto 12 Md DATE SIGNED 23 Apr 51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Cremation</u>	<u>Apr 24 1951</u>	<u>Green Mount</u>	<u>Balto Md</u>	
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/24/51</u>	<u>Wm. Reduch</u>	<u>H. Jenkins &amp; Sons Co</u>	<u>4905 York Rd.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Chas. Reier  
6701 York Rd.

M

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

3573

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Glyndon</b>		LENGTH OF STAY (In this place) <b>40 yrs</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Glyndon, Md.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Chatsworth Ave.</b>		STREET ADDRESS (If rural, give location) <b>Chatsworth Ave.</b>			
3. NAME OF DECEASED (Type or Print) <b>Fannie</b>		(First) <b>Richards</b>		(Last) <b>Yeatts</b>	
4. DATE OF DEATH <b>April 23, 1951</b>		(Month) <b>April</b>		(Day) <b>23</b> (Year) <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 16, 1864</b>	9. AGE last birthday <b>87</b> yrs.	If under 1 year Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore County</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Richards</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY No. <b>None</b>		17. INFORMANT <b>Yeatts Wilson, Glyndon, Md.</b>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>Coronary Occlusion</b>	<b>1/2 hr.</b>
Antecedent cause(s) (b) <b>Arteriosclerotic C-V. Disease</b>	<b>8 yrs.</b>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION <b>None</b>
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <b>No.</b>	PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY <b>None</b>
(CITY OR TOWN)	(COUNTY)
(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>None</b> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> <b>None</b>
HOW DID INJURY OCCUR? <b>None</b>	

22. I hereby certify that I attended the deceased from **1-23**, 19**39**, to **4-23**, 19**51**, that I last saw the deceased alive on **4-22**, 19**51**, and that death occurred at **9:30 A.** m., from the causes and on the date stated above.

SIGNATURE **D. D. Caples** (Degree or title) **M.D.** ADDRESS **Reisterstown, Md.** DATE SIGNED **4-24-51**

23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>April, 25/51</b>	NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>
DATE REC'D BY LOCAL REG. <b>4-25-51</b>	REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>	24. FUNERAL DIRECTOR <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>	

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED

MAY 3 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

3574

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>522 Ingleside Avenue</u>		STREET ADDRESS (If rural, give location) <u>522 Ingleside Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOSEPH</u>	(Middle) <u>FRANK</u>	(Last) <u>ZENKER</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>2/24/68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gasoline Sales</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Filling Station</u>	9. AGE last birthday <u>83</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>? Zenker</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>218-12-4776</u>	
17. INFORMANT AND ADDRESS <u>Walter L. Zenker 522 Ingleside Ave. Catons.</u>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocardial failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Senility(c) Arteriosclerosis, generalized

INTERVAL BETWEEN ONSET AND DEATH

7 daysUnknown11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?		
OF INJURY	While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from 30 Aug, 1948, to 4-29, 1951, that I last saw the deceased alive on 4-29, 1951, and that death occurred at 12:30 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/2/51</u>	<u>Loudon Park</u>	<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/1/51</u>	<u>V. E. Harry</u>	<u>Easton Stone</u>	<u>608 Frederick Ave., Catonsville, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

621608

RECEIVED  
MAY 3 1951  
BUREAU W. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3575 45

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Essex Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockaway Beach.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Turkey Pt Rd. Essex 21</u>	
3. NAME OF DECEASED (Type or Print) <u>Rosanna Zippler</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>17</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/12 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>74</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel B Eppard</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Bensley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Geo. L Zippler</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Coronary thrombosis

INTERVAL BETWEEN ONSET AND DEATH

1 day

## Antecedent cause(s)

(b)

Coronary sclerosis5 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1947, to April 17, 1951, that I last saw the deceased alive on April 15, 1951, and that death occurred at 1 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3526

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location) 1819 W. Lombard Street	
3. NAME OF DECEASED (Type or Print)	(First) GEORGE	(Middle) G.	(Last) ZIRKIER
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH 2-28-89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY Entertainment	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
13. FATHER'S NAME Carol W. Zirkler		14. MOTHER'S MAIDEN NAME Anne Haug	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY No. (If yes, give war or dates of service) Unknown	17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CARDIAC DILATATION AND HYPERTROPHY

INTERVAL BETWEEN ONSET AND DEATH

UNKNOWN

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

OBESITY

UNKNOWN

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☒ No ☐  
(STATE)

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April 22, 1951, to April 23, 1951, that I was the deceased

SIGNATURE and that death occurred at 8:40 A. M., from the causes and on the date stated above. DATE SIGNED

IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 4-23-51

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	4/26/51	Baltimore National	Baltimore	Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4/24/51	Dw. H. H. H.	Howard Blight Funeral Home	6009 Harford Road, Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.